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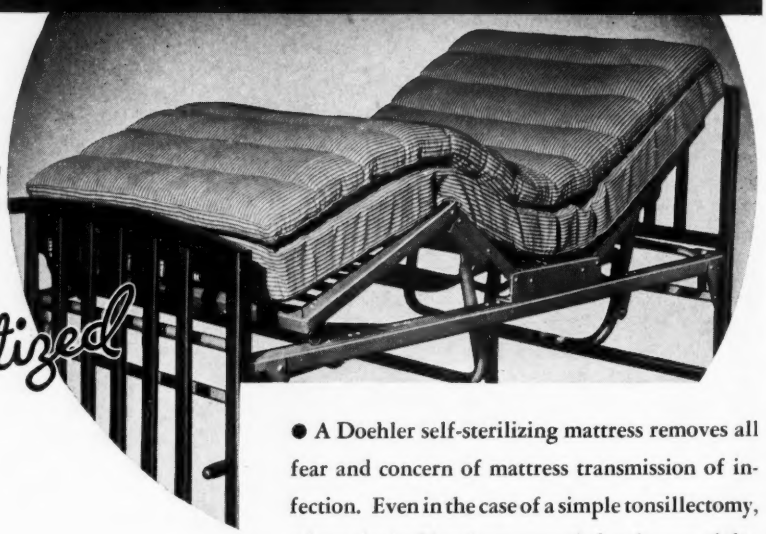

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HOSPITAL MANAGEMENT

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(Cover photograph, United States Naval Hospital, San Diego, Calif.)

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"To Talk of Many Things . . . ."

Abortions from The Statistical Point of View

» » Again the perennial question of where to place abortions in our statistical reports has been brought to my attention, with particular reference to the monthly analysis recommended by the American College of Surgeons.

In the first place, I could never see any good argument for classifying the abortion in any service except obstetrics. Some authorities wish to place them in gynecology, using the argument that they are caused by a pathological condition of the generative organs. But I question the truth of this statement. A vast number of abortions are undoubtedly due to syphilis, but I am not aware of any person even having suggested that they should be classed as communicable.

If you will study the tabulation in the monthly analysis you will note that both the section "Results" and the "Service" analysis section finish with "Total Discharges." Manifestly these two totals must agree, and equally manifestly a patient cannot be discharged who has not been admitted.

Aborting mothers are admitted and discharged, so would be included in both these statistical sections. Aborted infants and those that are stillborn are neither admitted nor discharged and so do not appear in either of these parts of the report. But it is desirable to have a record of the stillborn, so they are placed below the "Total Discharges" in the "Results" table. No specific place has been assigned for a record of the number of aborted embryos or fetuses.

Having these facts in mind, and in order to secure uniformity until such time as the monthly analysis form is revised, I recommend the following:

1. Results
   a) Stillborn. State the number of infants of a viable age born dead. While the lower limit of the viable age is variously stated it is suggested that seven months be used as the dividing line until a more authoritative ruling as to the viable age can be secured.
   b) Below Stillborn. Insert "Abortions" and state the number of embryos or fetuses below the viable age.
2. Service Analysis
   a) Obstetrics, delivered. State the number of mothers for whom the pregnancy is terminated, regardless of its p e r i o d s. Aborted mothers would then be included in this figure.
   b) Obstetrics, not delivered. State the number of pregnant women admitted but not delivered. This would then include threatened abortions which have been prevented from terminating in an abortion.
   c) Obstetrics, newborn. Include all live born infants. The tendency is undoubtedly to include these in pediatrics, but it is the form of the monthly analysis that we are considering. Placing them in the statistics of the obstetric division does not preclude treatment by the pediatrician and, since they are segregated, they can in actual fact be credited to the pediatric service, although listed under obstetrics.

Tissue Pathology With A Non-Resident Pathologist

I have recently been asked to outline the best method of handling tissue specimens in a hospital which has no resident pathologist. This question has been so thoroughly discussed that a reasonably definite routine can be stated.

1. Find out from the pathologist what medium he prefers for the preservation of the specimen until it can be in his possession. Have a liberal supply of containers and of the preservative in the operating room and treat the specimen in accordance with instructions.

2. Label the specimen showing hospital, name of patient, hospital number of patient and source of the tissue. See that the label is firmly attached.

3. Make one person responsible for transmission of tissue and subsequent care of reports.

   a) If there is a laboratory technician, she is the logical one to assume the responsibility. All tissues should be sent to her; she attends to the mailing and keeps a list of tissues sent the pathologist; reports, when received, are sent to her; she attaches the original to the patient's chart, files one copy in the laboratory and mails a second copy to the surgeon.

   b) If there is no laboratory in the hospital, some other person is made responsible. This may be the operating room supervisor or the medical records librarian. She will follow the same routine as in (a) above.

4. If at all possible, a copy of the surgeon's report of operation should be sent the pathologist. At least he should have the surgeon's diagnosis.

Hare vs. Tortoise

» » I have often heard that old story of the race between the hare and the tortoise and don't believe a word of it. Either Aesop made a mistake in the name of the animal he selected to run against the hare, or the tortoise has gone modern. Anyway he is the most erratic animal I know and this piece of information cost me some money.

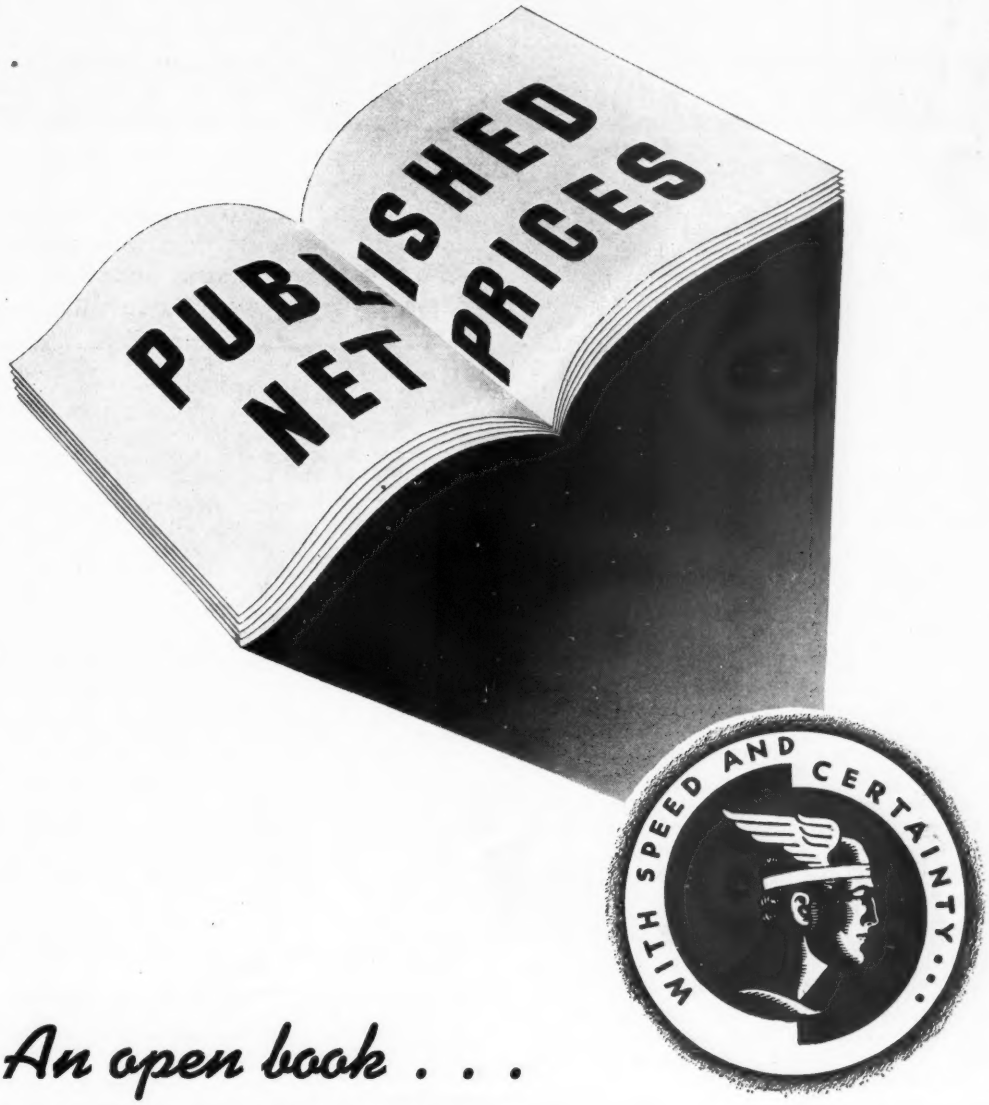
A few years ago I was invited to a picnic in the hot, dry middle west. The scene was a picnic resort with a trickle of water running by, a little shade, a lot of dust and many mosquitoes. Diversions were prohibition beer, hot dogs, a soft ball game for those who were energetic and the owner of the resort had some racing turtles, which were overworked.

The turtle race track consisted of an enclosure about thirty feet long and two feet wide. At one end was a puddle of water in which the turtles lived. When a race was on, the turtles were placed at the end away from the puddle, the general idea being that they would go home and get wet again. There was no start because they started when they pleased anyway.

I commenced betting on apparent form but that did not work. Either I did not know turtle form or they were not up to form that day. Finally I picked a turtle that had not won all day, placed him with his back to the track and bet that he would not win. He promptly turned around and made the only consistent race that I saw all afternoon.

Of all the brainless, erratic and undependable animals I have ever seen the turtle takes the prize. He insists on starting a race when he feels inclined; he meanders all over the track; he is apt to turn around at any time and go back to where he started from, and when it comes to taking an untimely nap he has the world beaten. For consistent effort the hare is a paragon as compared to the tortoise.

J. R. Ponton



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No. 517. The Continental Car-Na-Var Corporation has released a new four-page folder on its **floor treatments** and electric floor machines and other floor equipment.

No. 516. The Patterson-Kelley Co., Inc. has for distribution a new catalog on its line of Patterson **instantaneous water heaters** and heat exchangers for continuous hot water supply, circulation with storage tanks and hot water heating systems.

No. 515. Catalog No. 1102, published by the Brown Instrument Company, gives full details regarding the firm's multi-color numeral printing **potentiometer pyrometers.**

No. 514. Two folders recently issued by the Milwaukee Lace Paper Company describe and illustrate the firm's new **Souffle Cup Dispenser.** Other Milapaco items are also described.

No. 513. Catalog No. 15, **"Uniforms for Nurses",** has been published recently by the Waco Garment Manufacturing Company. Waco uniforms are cut and made to individual measurements.

No. 512. Howard Iron Works and Alberger Heater Co. has issued a new catalog entitled "Alberger Heaters". Described are the **commercial types of heaters** with accompanying engineering data, dimensions, etc. Also included is an alignment chart to determine the correct sizes of openings, pipe lines, etc.

No. 511. **"Baby Chart"**—a compact folder for distribution to mothers, describing essential points in the external care of the baby. Published by The Mennen Company.

No. 510. Bulletin 101, on **"One-Half Cent per Kilowatt Hour Power Cost"**, published by Troy Engine & Machine Co., tells the story of how forty-three institutions and concerns in twenty-nine industries cut power costs for driving nineteen different types of auxiliaries to an average of one-half cent per kilowatt hour.

No. 509. Bulletin No. 35-67A on ADSCO-Bannon **Tile Conduit** and ADSCO-Corning **Filler Insulation** for underground steam or hot water lines has been published by the American District Steam Company.

No. 508. The Emerson Electric Manufacturing Co. has issued the 1938 catalog of its **electric fans.** Many models of oscillator, ceiling, ventilating and exhaust fans are included.

No. 507. Voorhees Air-Pad **Sheet Rubber Flooring** is the subject of a folder recently made available by the Voorhees Rubber Mfg. Co. Advantages of this new resilient floor covering are enumerated in the folder, and photographs of installations are shown.

No. 506. Reynolds Electric Company has available a mailing piece on its combination **food chopper-slicer-grater-juice extractor and coffee mill.**

No. 505. Issued this month by the Standard Wall Covering Co., Inc. is a new catalog of Monowall **panels for covering walls.** Monowall, which may be used in place of paper or paint, is a chemically, waterproofed fibre panel, and is made in several different patterns.

No. 504. U. S. Stoneware Company has recently issued a bulletin which illustrates and describes its new "Flexlock" **rubber joints for piping.**

Request to Hospital Management will bring these new folders and latest information about equipment and supplies. Ask for them by numbers for convenience.

No. 500. Worthington Pump and Machinery Corp. has issued a new bulletin on their improved single stage **steam jet ejectors.** The bulletin contains information on typical applications of these machines.

No. 499. John R. Mitchell & Son, Inc., specialists in hospital and **institutional laundering,** have issued a booklet entitled "Where Do the Holes Come From?" Some of the subjects discussed in the book are: Causes of fabric depreciation; washing materials and methods; materials developed to minimize depreciation in the laundry, etc.

No. 498. New broadside has been released by Troy Laundry Machinery Division of American Machine and Metals, Inc. on the firm's new line of Atlas **washing machines.**

No. 495. **"Chemical and Biological Laboratory Instruments",** Catalog No. 38HM, is announced by the American Instrument Company. It presents information on the latest developments in the firm's scientific instruments.

No. 490. The Barnstead Still & Sterilizer Company has released a new bulletin on the latest models of the **"Longwood" Instrument Sterilizer,** which uses hot oil as the sterilizing medium. Photo-micrographs are used in the bulletin to show the protective feature of hot oil.

No. 489. "The story of the Electro Sheet", a modern **rubber-electric heating pad,** has recently been published by The Seamless Rubber Company.

No. 485. General Electric X-Ray Corporation has for distribution an eight-page book on its RT 1-2 Rotating Anode Coolidge Tube, an **X-ray tube** to cover the entire field of diagnostic roentgenography.

No. 479. **"The Care and Handling of Hospital Rubber Goods"** has been published by the Surgical Division of the Miller Rubber Company, Inc. The booklet will be of considerable value to those in the hospital whose job it is to obtain the maximum use from rubber goods.

No. 473. Two booklets have been published recently by Westinghouse X-Ray Company, Inc., on its new low-priced **X-ray unit, the Pandex.**

No. 467. Complete catalog of products, illustrations and descriptions of the many **Curity ready-made dressings and dressing supplies.** Lewis Manufacturing Company.

No. 465. **Roche Price List Supplement.** To bring your hospital price list of Roche pharmaceutical specialties up to date, Hoffman-La Roche has issued a supplement dated 1938. Price reductions and changes are announced in connection with Berocca (synthetic Vitamin B_1 Roche), Imadyl Unction, Larocaine Hydrochloride, Oleo-Bi and Vitamin C. The supplement includes a complete schedule of hospital prices on the new Vi-Penta Perles, containing vitamins A, B_1, C_2 (G), C and D. Time saving order blanks for Roche products are gladly furnished at any time.

No. 464. Engineering and installation **data for sterilizing equipment** will be gladly furnished by the Wilmot Castle Company. This firm invites correspondence relative to problems dealing with sterilizer installations. Consultation is without obligation.

No. 463. Catalog of **Boro Suture Needles** published reecntly by the Boro Surgical Company, contains price list and illustration of firm's line.

No. 461. Two descriptive folders covering the Angle line **of institutional furniture** are available for distribution. James L. Angle Company.

No. 459. **"Hospital Service Book and Catalog No. 3,"** issued by Johnson & Johnson, contains editorial material about surgical dressings, sutures, etc.

No. 458. **"Case Studies,"** a booklet by an authority on medical records which tells what constitutes a good case history and describes its use and value. Physicians' Record Co.

No. 453. **"Feeding for Health."** 20 pages of illustrated information on the achievement of higher standards of food service at low cost. A score of actual photographs and architects' plans of Pick kitchen installations in modern hospitals are included. Bedside Service, Cost of Operation, Space Allotments, Sanitation, Personnel Dining Rooms and Planning New Hospital Kitchens comprise but a few of the many subjects covered. Albert Pick Co., Inc.

No. 451. **"The Modern Method of Controlling Sterilization."** A descriptive and informative pamphlet which explains the Diack Control and indicates precautions for its proper use. Included are many interesting facts concerning the characteristics and correct operation of small and large autoclaves, and the use of drum and other types of sterilizing containers. A. W. Diack.

No. 445. **"Floor Reconditioning."** Descriptive material concerning the full line of floor maintenance machinery manufactured by the Lincoln-Schlueter Floor Machinery Company. Sanding, Steel-Wool Cleaning, Polishing and Scrubbing machinery is detailed and illustrated in this catalogue.

No. 444. A series of brochures describing the following **Curity products:** Layettecloth Diapers for hospitals, Lisco and dressing rolls, selvage gauze, bandages, cotton balls, Cellucotton absorbent wadding, Curity gauze, gauze and Lisco sponges, combination pads and rolls, dressings simplification, orthopedic products. Published by the Lewis Manufacturing Company.

No. 441. **"Sanitation Products for the Hospital."** A complete catalogue of Surgical and Baby Soaps and their dispensers, Baby Oil, Disinfectants, Floor Finishes, Floor Waxes, Furniture Polish, and other Hospital and Institutional supplies. The Huntington Laboratories.

No. 440. **"Relating to the Selection, Arrangement and Installation of Sterilizers."** A twenty-four page booklet containing 38 drawings and plans of various types of sterilizer, urinal, autoclave, and condenser units, as well as floor plans of typical installations. American Sterilizer Company.

No. 436. An eight-page booklet describing and illustrating uses and installations of **Acousti-Celotex** in hospitals. The manner in which this material acts and methods of its installation are completely described. The Celotex Corporation.

No. 429. **"Vitamin C—Cevitamic Acid, Synthetic."** Nature, chemical characteristics, indications for administration, diagnosis of vitamin C deficiency, and the employment of the synthetic in a number of other conditions is discussed interestingly in this pamphlet. Hoffmann-La Roche, Inc.

No. 428. **"Vitamin C Titration** with Dichlor-phenolindophenol—A Method for the Diagnosis of Prescorbutic Conditions." Written in non-technical language, this pamphlet clearly explains the technique its title indicates. A bibliography of literature on this subject is also contained in the booklet. Hoffmann-La Roche, Inc.

No. 424. **"Why Matting?"** a four page folder issued by American Mat Corporation, describing the advantages of rubber matting for use in building lobbies.

No. 422. **"Program Sound Systems."** A descriptive, illustrated twelve-page booklet, explaining the application of the Western Electric Company's sound distribution system.

No. 413. **"Standardized Hospital Record Forms."** Approved forms for professional service, administrative, accounting and all other departments. Physicians' Record Co.

No. 412. **"Alphabetical Indexing,"** describing the alphabetical disease and operation indexes; also other essential indexes as statistics cards, patients', physicians', X-ray and laboratory. Physicians' Record Co.

No. 404. **"Modern Surgical Illumination."** A new pamphlet describing recent and important developments in surgical illumination, prepared by the Wilmot Castle Company.

No. 392. **"Maintenance Cleaning Illustrated."** This booklet covers the entire field of maintenance cleaning. J. B. Ford Co.

No. 252. **"Scientific Hospital Meal Distribution."** Swartzbaugh Manufacturing Company.

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T. R. PONTON, B.A., M.D., Editor

As The

MATERNAL CARE

» » In recent years there has been much discussion regarding maternal care, particularly as its quality is reflected in mortality and morbidity. The medical profession, hospitals, and the lay public have interested themselves in the subject and numerous statistical studies have been made. Comparison with the maternal death rate of foreign countries appears to show that it is still high in the United States. Unfortunately, as a result, much has been said and written which has exaggerated the belief that the greatest possible precautions are not being taken to conserve the life and health of the prospective mother. This has had the effect of making some obstetrical patients dubious about the advisability of entering the hospital for childbirth. Indiscriminate publicity on the matter of maternal welfare should be discouraged, but everything possible should be done to improve the maternal care, with the consequent reduction in mortality and morbidity, and to keep the public informed as to the results.

We are told that every fifteen seconds a baby is born in the United States, and of these, one in three begins life in a hospital. In other words, in some hospital a baby is born every 45 seconds or approximately 750,000 of the 2,000,000 annual births throughout the nation. Despite the fact that all serious and complicated cases go to the hospital, the maternal death rate in approved hospitals in 1936 was only 4 per 1000 as compared with a national death rate of 6 per 1000.

In 1935 the United States Bureau of Census reported the cases of maternal mortality as follows:

Puerperal Sepsis	
Due to abortion	17.3%
Not due to abortion	24.0%
Albuminuria, Eclampsia and other Toxemias	21.7%
Other accidents of childbirth	12.3%
Puerperal Hemorrhage	10.9%
Non-septic Abortion	4.8%
All other causes	9.0%

From the above it is apparent that practically 60 per cent of the maternal deaths are due to such preventable causes as infections and toxemias, conditions which can be prevented through adequate prenatal care supplemented by efficient medical, nursing and other services during labor, delivery and the puerperium. In this preventive work the hospital is vitally interested since control of morbidity and mortality rests on the intelligent cooperation of the patient, the hospital, and the physician.

There are certain conditions, stated in the minimum requirements of the American College of Surgeons, which must prevail in every hospital caring for obstetrical patients in order to give the most safeguarded care.

Architecturally and administratively, obstetrical patients should be segregated from all others. This is most essential because of the susceptibility of this type of patient to infection. In many instances such adequate provision for protection is not rigidly observed and other patients are left in grave danger of infection, an unjustifiable risk. It needs no argument whatsoever to support the requirement that the obstetrical patient should be completely segregated in accommodations and services from other patients in the hospital.

All patients with temperatures or other sign of infection should be isolated immediately. This presupposes that they be taken out of the section and cared for by separate personnel. Frequently too much risk is taken with the patient having a moderate fever, a slight cold, showing signs of a sore throat, or having some other minor infection about the body. These are simple, common, everyday conditions, but they may be the source of serious danger, not only to the patient herself, but to others in the ward or division.

The absolute segregation of personnel working in the obstetrical department is imperative if we are going to build up a security against infections. This may be difficult in the small hospital but it is just as essential here as in the large. Nurses and interns on obstetric duty should be allowed to work only in the department. They too must be free from colds, sore throats, focal infections and other sources of danger to the patients whom they are serving. They must use the strictest precautions, and unless these can be observed, the hospital should not admit obstetrical patients.

Administrative control is indispensable. Every obstetrical department must be under a capable supervisor who has not only administrative ability but who has been specially trained in this particular technique. She must have, in addition to managerial acumen, the personality make-up that is essential in all administrative positions in a hospital but is especially imperative when dealing with patients of this type.

The professional control of the work is another vital factor. This must be exercised through the medical staff and more specifically the obstetrical service. It presupposes a chief or head of the department who is a recognized, qualified obstetrician and also, when possible, a competent resident. Such professional or clinical control is one of the vital factors in preventing poor obstetrics.

Too many hospitals have relaxed professional control and permit any doctor to attend obstetrical cases, to do his own operative work and to treat the serious complications which require great skill and experience—all this without any supervision by or assistance from recognized authority. This lack of control constitutes the weakest point in the whole picture. A chief or head of the department who has authority and who is alert will see that the work is kept efficient and the results will be shown in lowered mortality and morbidity rates.

A survey shows obstetrical records to be deficient in a large number of hospitals—again an apparent laxity. Every patient, to be safeguarded and assured of the best treatment, should have a proper obstetrical record, comprising pre-natal history together with pregnancy, labor and puerperium records, in conformity with approved standards. Too often the obstetrical records lack some most essential data, particularly pelvic measurements, and indication for operative procedures. Every patient should be measured early in pregnancy to determine the size of the head of the foetus in relation to the pelvis. If this is done before the seventh or eighth month, steps can often be taken to avoid the complications of distocia at delivery. Indications for operative interference should always be carefully recorded before an operation is undertaken, another factor contributory to the safety of the patient.

In no other service of the hospital are consultations more indicated and more desirable than on the obstetrical service and the consultant should be with a trained obstetrician. This is particularly true for private patients who so frequently lack pre-natal care and are attended by general practitioners who have only casual experience and little or no training in obstetrics other than that secured through general practice. The attending physician may call consultations with his office partner, his neighbor doctor or a surgeon, in case of operation, but of what value is such a consultation unless the consultant happens to be a qualified obstetrician such as the head of the department or one whom he may delegate. The rigid enforcement of the rule for consultations on major operative or abnormal obstetrical cases is most imperative.

In some hospitals the incidence of operative obstetrics is far too high. For example, a number of institutions show a high percentage of Caesarean sections, instances having been found of from twelve to nineteen per cent. It is obvious that this is excessive and inexcusable; fortunately it is rare. A rate of over three or four per cent should be looked upon with suspicion and a check made as to the cause for such a condition. It should be emphasized that no operative obstetrics be allowed without consultations, as already stated, the selection of the consultant being most important.

Insufficient attention has been given in the past to morbidity rates in the obstetrical department of the hospital. The slight temperature may be indicative of pending onset of infection, and no risk can be taken with other patients. As a good measure of control, the adoption and strict observance of a morbidity standard is not only desirable but most essential and in this connection hospitals are urged to adopt the standard recommended by the American Committee on Maternal Welfare which reads as follows:

"Temperature of 100.4 degrees F. (38 degrees C.); this temperature to occur on any two of the first ten days postpartum, exclusive of the first 24 hours, and to be taken by mouth by a standard technique at least four times a day."

This affords the administrator and the medical staff a practicable index or gauge in controlling and studying possible infections and the better determination of end results. It affords the administrative staff a specific measure to guide them in taking precautionary measures. It is, in effect, a flagging of pending trouble.

The carrying out of the requirements as laid down by the American College of Surgeons will insure the most reasonable safety to every patient admitted to the institution, and all these elements are easy to make effective. Laxity, however, in the enforcement of any requirement will endanger the patient.

Appraisal of the Work of Individual Physicians

By THOMAS R. PONTON, M. D.
Editor, HOSPITAL MANAGEMENT

» » » THE GOVERNING BODY has an acknowledged responsibility for taking every reasonable precaution to see to it that the patient receives the best possible care, a responsibility which predicates careful attention to two factors: provision and management of personnel and facilities required for the hospital's part in the treatment of disease or disability, and the selection and organized control of the physicians who will be held responsible for directing the treatment.

Provision and management of personnel and facilities is mentioned first, not because it is greater in importance, but because this responsibility is usually recognized and fulfilled insofar as money and other factors permit. The real weakness in our hospital system lies in the organized medical staff. It is not implied that the medical staff in our hospitals is incompetent, indifferent or unethical. On the contrary, after many years of intimate contact with physicians of all classes, the writer is of the opinion that the vast majority of physicians are ethical, conscientious and competent. There is, however, a minority, among whom will be found some who are guilty of unethical practices, others who are competent in one field but who may attempt work in other fields which they are not qualified to do, and still others who are generally incompetent. These physicians should be limited in the work they are allowed to do, their weaknesses should be corrected or they should be prohibited from attending patients in the hospital.

This state of affairs throws a great responsibility on the governing body, and it is the responsibility which is more neglected than any other. The reason is quite apparent. The governing body, being composed of men who are not medically trained, is not qualified to exercise judgment as to the competence of a physician. They must delegate that responsibility to a group of physicians as found on the medical staff, an organization which often does not have a sufficient realization of the importance of their duty.

Judgment as to Ethics

The exercise of fair and impartial judgment is no easy matter, particularly with regard to ethics and honesty. Unethical and dishonest practices, such as fee-splitting or other forms of commercialized medicine, are carried on under cover and rarely can definite evidence be secured. Yet, the conscientious governing body, with its medical staff acting in an advisory capacity, is obligated to see that the patient is treated honestly. It may be possible to secure such evidence as would be accepted in a court, in which case the governing body is obliged to prohibit the physician involved from practicing in the hospital until such time as it is convinced that the unethical practice has been discontinued. In other cases the governing body and the medical staff may have such strong presumptive evidence as to be morally certain of the guilt of the individual, and should therefore refuse or cancel staff appointment. The greatest caution must, however, be exercised to see that an injustice is not done to any individual. It would be better to condone or overlook suspected unethical practices than to injure the individual by an unjust accusation.

The governing body must also exercise caution in its own interest. It may be morally certain of the guilt of an individual, but may not have evidence which would be accepted in a court. If a reason be given for cancelling or refusing an appointment and that reason cannot be substantiated by evidence, the hospital would certainly be found liable in any action for damages which might be entered. On the other hand, the governing body is not obliged to give a reason for any action which it might take, and if it does not do so would not have been guilty of libel. Unless the case is very flagrant it may be advisable to temporize and refuse to reappoint the member at the end of the year.

Judgment as to Professional Competence

The question of professional competence is one which is more susceptible to accurate judgment if the decision is based on proper premises, which necessitates that accurate records be kept of the work of each physician.

The most common custom in making appointments to the medical staff is to rely on opinion which is based only on observation, daily contact and reputation, a method which may do injustice to the physician, often results in making improper appointments and is utterly unworthy of consideration in a scientific institution such as the hospital. Opinions formed without a demonstrable basis may be entirely fallacious. Some of us are inclined to remember successes and forget failures, while with others the tendency is to remember the failures of their associates. In either case the reasonably accurate judgment which is demanded in so important a matter is not exercised, with the result that many improper appointments are made.

The death rate is sometimes given a great deal more value than it deserves. Consideration of the death rate alone may lead to very erroneous conclusions. For example, an eye specialist treats very few cases in which there is any hazard to life. On the other hand, a surgeon doing a great deal of traumatic surgery may be justified in showing a very high death rate. To make any compar-

ison of these two surgeons, based on the death rate alone, would constitute a grave injustice, and any appraisal of the work of either made on the same basis would be extremely inaccurate.

Judgment Should Be Based on Records of Individual Physicians

It is manifest that to obtain an accurate and just appraisal of the work of any physician of the staff, it is necessary to have a record of the results obtained from treatment as compared with those which may be justifiably expected. The results should not be merely the death rate, but also, as is so strongly and frequently emphasized by Codman, the morbidity as shown in the end results in the cases of those who do not die. At the present time end results are secured in comparatively few hospitals and mortality is the only possible basis of appraisal. While this is imperfect and incomplete, it is the best record that can be secured in most institutions at the present time and is better than no record at all. Moreover, it is a beginning from which a complete and final appraisal of mortality and morbidity can eventually be evolved.

In order that the record may be of value it must be systematized. The best system yet suggested is that advocated by the writer about eight years ago and approved by the American College of Surgeons. In outline it is as follows:

1. On admission the attending physician states his prognostic appraisal of the risk or the results he expects to secure, in one of nine prognostic categories:

1—Elective	Good
2— "	Fair
3— "	Bad
4—Emergency	Good
5— "	Fair
6— "	Bad
7—Palliative	Good
8— "	Fair
9— "	Bad

2. If the risk is not good, he must state his reason for classing it as fair or bad.

3. A committee appointed by and representing the staff has authority to review the case and, with or without the consent of the attending physician, may change his estimate of the risk if it is not considered to be correctly stated.

4. On discharge the immediate result is shown as died or recovered.

5. The estimate of the risk and the immediate result are indexed to the attending physician giving an accurate record of the immediate results actually secured as compared to the risk involved.

6. If possible end results are later secured and morbidity results are added.

A complete description of the working of the system will be found in Doctor MacEachern's two works, *Hospital Organization and Management* and *Medical Records in the Hospital.*

The writer is sufficiently optimistic to express the hope that the time is not very distant when a record will also be kept of the errors which occur. Perhaps "errors" is not the right expression. The word is used for lack of a better one, not to indicate culpable errors but rather that events have not followed the course which was expected by the physician and that he is inquiring into the reason. For example, there is an error in judgment when the resistance of the patient has not been properly estimated. This cannot be considered a culpable error since there is no definite yardstick for measuring resistance. A study of such errors will, however, increase knowledge of resistance and so decrease such errors. Other errors which may be suggested for study are errors in diagnosis, errors in selection of treatment, errors in technique and errors in post-operative care.

Proper Use of the Records Of Individual Physicians

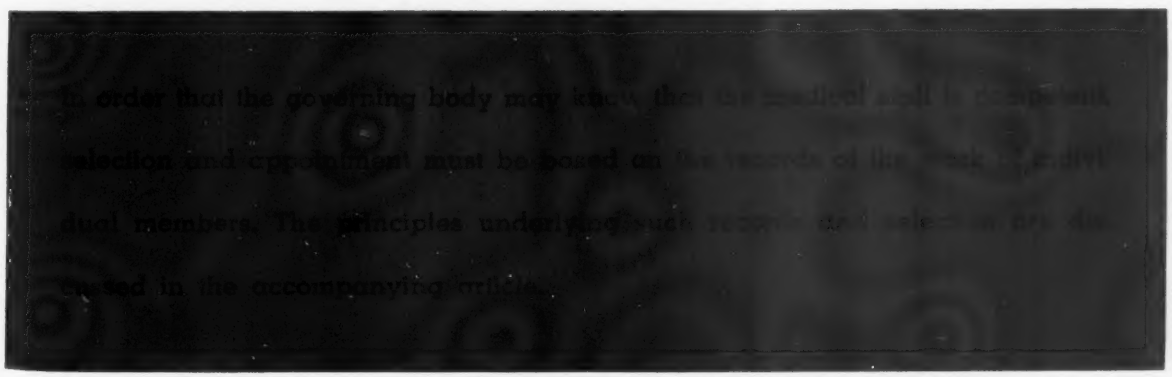
It is perhaps needless to emphasize the necessity for guarding the use of such records with the most scrupulous care. If properly kept and used they can be of the greatest value to the individual physician and to the medical staff as a whole as well as to the hospital and its patients, but if the data contained is given to those who are not qualified to interpret it properly or to those who may violate its confidence, infinite harm may result to all.

Each physician should be allowed access to the record of his own work and by studying it he has an accurate statement of his successes and failures. Such knowledge cannot fail to increase his successes and decrease his failures.

The record may be of value to the program committee for impersonal use. The medical records librarian, who keeps the record confidentially, may indicate cases for discussion which would be of great value educationally.

Undoubtedly the greatest value of the record of the work of individual physicians is that it enables the governing body to make appointments to the staff with equity and in

(Continued on page 48)



Disinfection of MATTRESSES.

Hospitals go to a lot of trouble to prevent cross-infection but very often neglect the mattress or are satisfied with uncertain sterilization. This is largely due to improper use of the apparatus supplied. In this article, Weeden B. Underwood, research engineer of the American Sterilizer Company, discusses the errors and gives the remedies.

» » » WHAT TO DO with soiled and infected mattresses, pillows and bed linen has become one of those problems we don't like to talk about in most hospitals. There is a degree of danger involved in reuse without sterilization and certainly the idea is offensive. To scrap mattresses known to be infected, as sometimes practiced, involves prohibitive expense and to sterilize them under haphazard methods is only a degree less costly because the excessive heat and moisture so often used brings about quick decay.

To date there is no satisfactory substitute for steam sterilization, nor is there any need for a substitute if we apply some scientific thought to the sterilization of mattresses that has reduced surgical sterilization to a precision system. Properly harnessed and controlled, steam can be used to bring about dependable sterilization of all bedding, except woolen blankets, with very little destructive effect. It will be our purpose to trace the source of present difficulties, to show the faults in the older system which have made disinfecting apparatus unpopular with some executives and to suggest ways and means for accomplishing the desired results.

The Disinfecting Plant

Granted the disinfection room in the basement is not a department over which one can wax sentimental. It isn't a show place under most ideal conditions. The public doesn't see it and no one ever goes there except of necessity But this constitutes no excuse for making this room a general catch-all for discarded machinery, worn out furnishings and for permitting the walls and floor and equipment to accumulate dust and rust. True enough, the materials handled here are not intended for surgery. They do not need to be handled with the same care as surgical supplies; they need only to leave this department free from those organisms which cause the communicable diseases. Nevertheless, the space in which this work is done should correspond, insofar as is practical, with the work room in the surgery. There is no incentive for the operator of the disinfector to maintain sanitary standards unless the room he works in lends itself to those standards. The following examples will illustrate some of the faults in management which contribute greatly to existing unsatisfactory conditions.

In a large municipal hospital complaint was made that a disinfector only a year old was delivering mattresses wet, burned and badly discolored. Examination disclosed that the operating directions had been completely ignored by the two foreigners assigned to the handling of the machine.

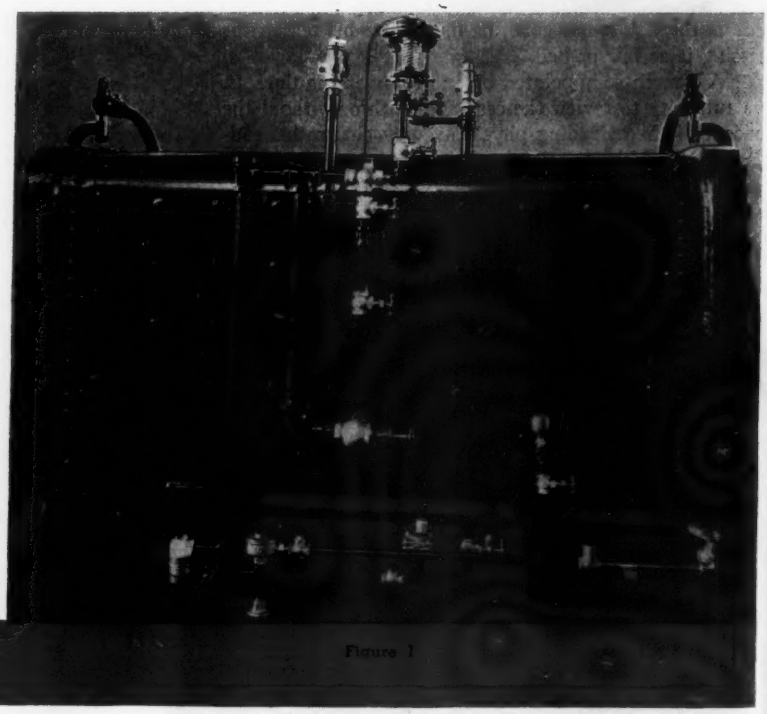


Figure 1

Figure 1. Side view of a modern disinfecting machine. This apparatus, identically the same machine used extensively for surgical sterilization in the largest and most exacting hospitals, will steam sterilize mattresses, pillows and bed linen with the same precision. When the machine is properly used, the materials will not be damaged any more than surgical supplies are damaged.

Figure 2. (on opposite page) This type of drop wheel carriage has been developed to facilitate the handling of heavy loads. No outside tracks are needed. The front wheel support folds back against the end of the carriage during sterilization as shown by Figure 3.

Figure 3. (on opposite page) Showing the newly developed drop wheel carriage with the wheel support folded back in position for closing the door of the disinfector. This system eliminates the former extension tracks which had to be removed and replaced with every operation.

PILLOWS AND BED LINEN . . .

Neither could read English and there was no supervision of the work. The regulator was set at too high a range of pressure but the main difficulty came from a completely clogged chamber drain which held in all condensate. The drain line thermometer, provided for such emergencies, indicated no change in temperature and neither operator knew what the instrument was intended for, although the directions for use clearly prescribed operation of the machine based upon maintenance of 240 to 250° F. as indicated by it.

In another hospital, every questionable mattress with pillows and bed linen is sent to the basement for disinfection. The disinfector room is well isolated, but it serves also as communication access to a pipe tunnel leading to the boiler house. The walls are unfinished and the floor is uneven and badly cracked. In the same room are stored a pipe threading machine, a large discarded water heater, several piles of rusted iron pipe and various odds and ends of machinery. The disinfector has never been insulated and is covered with rust. It has never been painted or cleaned since installation many years ago.

An orderly is assigned to the business of sterilizing once or twice a week, when and if he gets around to it. In the meantime, the mattresses are draped over the general debris accumulating more dirt and rust spots. The orderly is too busy to stay and finish his work, so hurries off to other duties and returns to turn off the steam in half an hour or perhaps in two hours. There is no definite supervision. The executive bewails the fact that disinfection is so hard on materials. Of course it is under such conditions.

Under the same hit-and-miss methods, it is common practice in many places to leave mattresses in the disinfector over night or perhaps for a day or two following sterilization, with the door tightly closed. There can be only one result from such treatment—damp and discolored and perhaps mildewed mattresses. The materials should be removed from the machine immediately after sterilization and left exposed for thorough airing, preferably separated.

It is unfortunate that there are no statistics to show just what losses are sustained every year by such improper disinfection. In the writer's opinion those figures would be startling. Perhaps the most glaring inconsistency is found in the delegation of such work to thoroughly incompetent help, men who have not the slightest idea of the principles involved, working without supervision. Unusual intelligence is not required but at least the operator should be thoroughly trained by someone who does know what it is all about and there should be definite supervision. One of the best checks against carelessness and the most common faults is the use of a recording thermometer in a lock-up case and provision for daily inspection of the charts which record both temperature and the duration of the exposure.

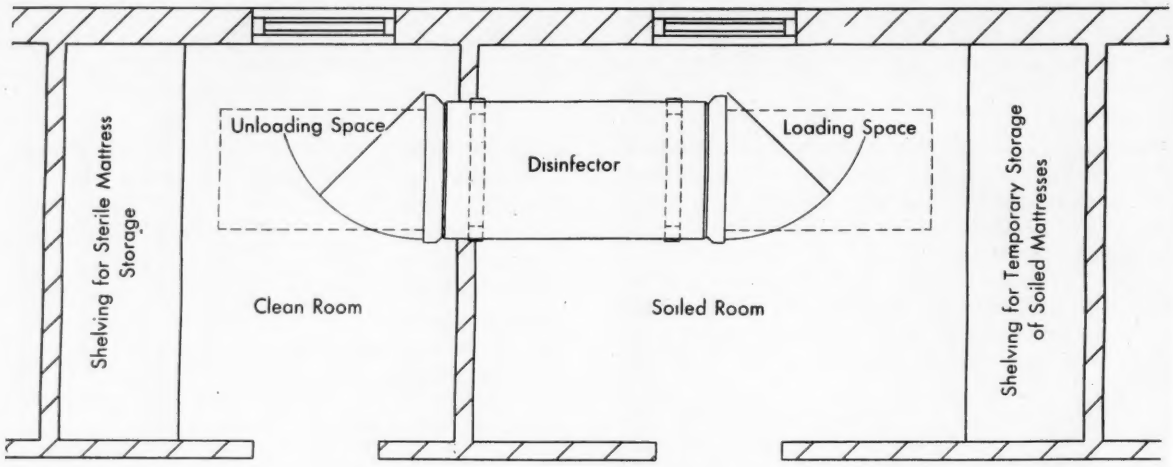


Figure. 5. This plan for a disinfection department is suggested as most suitable. Soiled materials are not permitted to enter the clean room from which the sterilized supplies are removed. Ample shelving for temporary storage of mattresses in a sanitary manner is essential.

Comparisons Between Old and New Ideas on Mattress Sterilization

Because mattress sterilization has been classified among the "necessary evils" in the hospital, progress in developing better machinery for the purpose has been retarded and the mistakes of earlier days have been perpetuated. Recent demands from executives of large hospitals for the insane, where unusually large numbers of mattresses are handled, has necessitated research which has disclosed the faults in usage which we have defined, but in our investigations it has become increasingly plain that the same principles which have made surgical sterilization a precision performance are equally applicable to disinfection processes and certain rather radical changes have been made to conform. The following six comparisons between the old and new ideas on this subject indicate the purposes served.

1. Former disinfectors were universally operated with full line steam pressure in the jackets, 40 to 60 pounds or higher, to no useful purpose whatever, but subjecting the machine to unnecessary strains and developing a significant degree of superheat in the chamber, highly destructive to fabrics.

Modern machines operate at 15 pounds jacket and chamber pressure, controlled automatically. This change eliminates one of the worst sources of burning.

2. The older system of pressure control, opposed to modern temperature control, called for chamber pressure of 20 pounds or more to overcome the expected inefficiency of the machine in eliminating air and developing load temperature. Operating efficiently, as they sometimes did, such machines would develop 10 degrees or more excess heat. Operating inefficiently, suitable temperature would not result in the load and the chamber would collect an excessive amount of condensate, wetting the load.

Under the new system, just as in modern surgical supply sterilizers, performance is gauged altogether by temperature, never higher than 250° F. The operating range is 240 to 250°F., amply protective and greatly reducing the destructive effect.

3. Due to the recognized inefficiency of pressure controlled sterilizers, it became common practice to sterilize mattresses under that system for a full hour or more, at the sometimes destructive temperatures indicated by paragraphs (1) and (2).

Operating under the new temperature system, 30 minutes' exposure to steam at 240 to 250°F. assures dependable disinfection (destruction of bedbugs, lice and their eggs and of all of the communicable disease organisms), the same identical sterilizing effect every time the machine is used, in half the former period.

4. The same causes which contribute to the ineffectiveness of sterilization under the old pressure control method also result in abnormal moisture in the load, undischarged condensate absorbed by the load, to an extent which prohibits adequate drying. Damp, foul smelling mattresses result from such treatment.

Temperature control with the thermometer located in the drain line from the chamber insures elimination of condensate unfailingly. Under this system the load is never subjected to abnormal moisture.

5. Drying of mattresses following sterilization, vaporization of moisture in the load and elimination of that vapor was accomplished inadequately under the old method by creating some minor degree of vacuum which left half or more of the vapor in the machine. Mattresses were never sufficiently dried and when the door was opened, a blast of hot vapor laden with foul odors escaped into the room and perhaps through the building.

The modern process uses the same ejector valve formerly used for vacuum but now used to pump filtered air from the room, through the chamber and up the vent stack. The heat residual in the load plus heat from the jacket vaporizes the moisture in the load and the stream of air passing through entrains the vapor with it, leaving the chamber free from moisture and the load satisfactorily dry after 15 to 30 minutes. Then when the door is opened there is no perceptible vapor discharge. This process is perfectly simple; it conforms with the requirements but it cannot be hurried.

6. Air and condensate from the chamber, under the old system, were conducted to a vent riser open at the bottom

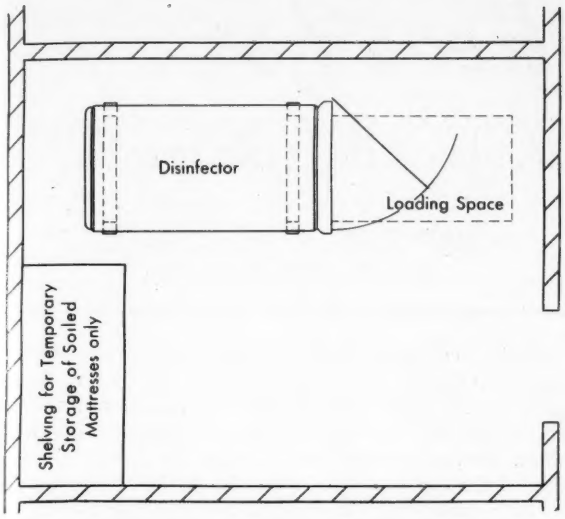


Figure 6. When space is restricted, this arrangement of the disinfection room can be used. The storage shelves should never be used for anything but contaminated materials. The sterilized supplies should be removed from the machine directly to the transfer truck to avoid contamination.

for drainage over a floor drain. Through this air break above the drain a considerable part of the gaseous discharge, vapor and odors, escaped into the room, helping to make the disinfector a nuisance since the odors permeated other parts of the hospital.

The new system employs two traps controlling the chamber discharge, a thermostatic trap which discharges into a drained vent riser. The drain connection is trapped by a condensation trap which discharges only water. Odors and vapor are conducted up the vent.

There is nothing complicated or mysterious about the theories which prompted the development of the new system of sterilizing which has been described. Every detail has sound engineering background and the performance has been repeatedly checked. With such apparatus it is easily possible to sterilize mattresses or surgical supplies with precision and without material damage. But to secure these results, there must be cooperation from the management. The operation of the machine must be prescribed and methods of loading must be defined and followed. If mattresses are rolled or crammed into the chamber in a solid mass, more time will be needed for sterilization and more time must be allowed for drying. This does not pay since the added time will bring about some destructive effect. It is not good practice to allow quantities of infected material to collect for days before sterilizing. That practice simply invites crowding and haste. It is much better to sterilize daily or oftener and to limit the loads so that mattresses can be separated from each other in the machine to allow for quick steam penetration and correspondingly quick drying.

In planning for a disinfection department it is desirable to secure sufficient space so that clean and soiled rooms can be arranged as shown by Figure 5. This arrangement calls for a disinfector with a door at each end. The machine is operated from the soiled room. If space is limited, the single door machine can be used as shown by Figure 6. With proper care in handling supplies there is slight danger of recontamination.

In selecting the disinfector it is much better to use the type of machine shown by Figures 2 and 3, wide enough to take the usual hospital mattress lying flat, one mattress on each shelf. The narrower machines necessitate putting the mattresses in on edge and it is very difficult to keep them from settling down into a tight mass through which steam is slow in penetrating. Sizes 42 inches wide, 48 inches high, 96 inches deep and 48 inches wide, 54 inches high, 96 inches deep are most suitable.

Figure 4. Disinfecting apparatus described in this article is extensively used in large hospitals for surgical sterilization. The heavy dense load illustrated was perfectly sterilized in thirty minutes' exposure to steam never in excess of 250 F. Results were repeatedly checked in a University hospital with a potentiometer.

Admission Polices for OUT-PATIENT DEPARTMENTS

By MARGARET LOVELL PLUMLEY
United States Public Health Service

» » » IN THE STUDY of hospital out-patient departments conducted during 1935 as part of the National Health Inventory of the United States Public Health Service, data which describe these institutions from administrative and service points of view were submitted by a representative group of departments. The general and certain special features of these departments have been presented on previous occasions[1]. Items bearing on selection of clientele, admission fees, and charges for special services, which form the basis of this paper, seemed worthy of detailed treatment in separate presentation.

In the total study groups were 769 departments, but not all of them gave full information in regard to the items listed above. Consequently, varying numbers of departments are involved in the several tabular presentations of data. However, it is believed that in each case a sufficient number of replies were received to portray the prevailing practice.

Residential Restrictions to Admission

Nearly one-half of the departments reported absence of residential restrictions for admission. The percentages given in Table 1 indicate that departments of non-governmental groups are less apt to impose such limitations than are those which are governmentally maintained. In fact, only nine per cent of the local governmental departments and twenty-seven per cent of those under state control, as contrasted with fifty-seven per cent of the departments of non-profit association hospitals and sixty-two per cent of those attached to church and fraternal institutions, reported a policy comprising no residential restrictions. Further study of Table 1 discloses that over one-half of the departments of State hospitals limit patients to state residents while an additional twenty per cent of these departments more specifically confine admission to inhabitants of particular districts of the state. Basic data not given in tabular form reveal that more than two-thirds of the departments under city control and four-fifths of those operated by counties restrict patients to inhabitants of their respective tax jurisdictions.

Information not susceptible of statistical presentation would suggest that necessity for restricting admission to those residing within a specified geographic area depends very largely upon the local demands for service. If only a few patients from outside the city in which the hospital is located present themselves for care, residence is not likely to be a barrier to admission. If, on the other hand, lack of out-patient department facilities in adjoining counties or a neighboring state results in requests for clinic admissions by many non-residents, out-patient department authorities may find it necessary to limit clientele to persons living within the community which supports the parent hospital.

From the Division of Public Health Methods, National Institute of Health. Study conducted in connection with the National Health Inventory.

TABLE I

Percentage distribution of out-patient departments operating under different agencies according to residential restrictions for admission of patients.

Agency in control	Number of departments	Percent of departments under each control which reported specified residential restrictions				
		No restrictions	State	Two or more counties	County	City[1]
All types	729	46	6	4	23	21
Governmental						
Local	149	9	1	1	57	32
State	56	27	53	11	9	—
Nongovernmental						
Nonprofit association[2]	383	57	2	6	16	19
Church and fraternal	141	62	3	1	11	23

[1] Including those restricting admission to (1) residents of a particular section of the city, (2) residents of the city or its metropolitan area, and (3) residents of the city or a section of the county adjacent to the city.
[2] "Nonprofit association" in this and other tables refers to nongovernmental associations and corporations (other than church and fraternal) not organized for profit.

Racial Restrictions to Admission

Negroes are accepted as patients in over ninety per cent of the 688 departments reporting on this item. It is apparent, therefore, that racial restrictions are not an important factor affecting the intake of clinics. There are, however, forty-five departments which stated that negroes are excluded, while fourteen admit negroes only.

Twenty-five of the forty-five departments limited to white persons and twelve of the fourteen accepting negroes only are located in southern or near-southern cities. Five of the departments excluding negroes afford the only out-patient department service in their communities. Except in these instances out-patient service is available to negroes in other departments located in the same community.

Socio-Economic Factors Affecting Admission

Replies submitted in the section of the schedule devoted to socio-economic factors affecting admission indicate that a large number of departments do not have a sufficiently clear-cut policy in regard to socio-economic standards of admission to permit their making a definite statement on the subject. Thirteen per cent left this section blank and forty-one per cent replied variously that "all the indigent are eligible," or that "anyone unable to pay a private physician is accepted," or made similar vague and unsatisfactory statements.

The 351 reporting departments have been enumerated according to the types of information supplied:

1. (a) One hundred and eight departments made brief statements indicating that the admitting officer in determining socio-economic eligibility for admission took into account such factors, in addition to income, as: regularity of employment, number of wage earners, size of family, previous illness, cost, type, and duration of present illness, debts and other relevant items. (b) Thirty-two additional departments noted the importance of the factors just mentioned and enclosed a rather complete statement of policy. All except two of these thirty-two and fourteen of the others included the income guide utilized.

2. Seventy-three departments stated or implied that patients were ordinarily admitted under one of the three following conditions: (1) on reference by physicians or by recognized social agencies, (2) on presentation of relief cards, (3) on endorsement by city, county or township authorities.

3. Sixty departments reported the use of standard budgets prepared by some central organization or of an income guide and policy formulated by a coordinating committee composed of representatives of such bodies as the County Medical Society, the Community Chest, the Council of Social Agencies and the departments concerned.

4. Forty-eight departments (almost all attached to mental and tuberculosis hospitals) stated that need of examination or treatment was the chief factor determining eligibility for admission; therefore, the socio-economic status of the patient was of minor importance.

5. Thirty departments merely noted the income limits beyond which patients were not accepted.

Worthy of mention is the fact that approximately a fourth of the entire group studied (see points 1 and 3) recognize the importance of medico-social factors as well as of income in determining admission. The significance of the use of common standards by 92 departments (points 1b and 3) would be greater were it not that half of the departments are located in two large cities. The apparent inability of so large a number of departments to outline their standards of admission makes evident the necessity for continued emphasis on this important phase of out-patient department administration.

Admission Fees

Variations in the fee policies determining admission to hospital out-patient departments have been discussed in previous articles. One of these studies[2] was devoted to consideration of 174 departments which submitted usable

TABLE II

Percentage distribution of out-patient departments providing selected special services according to the fee policy reported for each service.

Types of special services provided	Number of departments which provided designated special services	Percent of departments providing each service which maintained specified fee policy		
		Fee always charged	Fee remitted if necessary	No fee charged
Ordinary prescriptions	545	17	55	28
Special prescriptions	518	29	51	20
X-rays	641	20	61	19
Routine laboratory tests	619	11	42	47
Special laboratory tests	593	19	52	29
Appliances	482	34	48	18
Salvarsan	494	22	48	30
Insulin	482	32	49	19

information on expenditures and income. This selective group represents the larger departments, disproportionately weighted with those under non-governmental control, which, for the most part, are located in highly populous cities. As a result, the initial admission fee for these 174 departments tends to be somewhat higher than for the total group departments.

The summary report of the out-patient department study [3] contains a discussion of the fee policy of all 702 departments (ninety per cent of the total group) which reported on this item. The findings may be briefly summarized as follows: About one-third of the reporting departments stated that admission is always free, while about one-fourth of them make an initial charge of 25 cents and nearly the same number charge 50 cents. Only 12 per cent reported a fee of $1.00 or more.

A much higher percentage of governmental than of non-governmental departments habitually admit out-patients without charge. Moreover, when charges are made, the rates are higher in non-governmental than in governmental departments. Institutions operated by local governmental agencies are less rigid in their charges than those operated by states, and church and fraternal departments are more lenient than those sponsored by non-profit associations.

In considering these figures, it should be emphasized that the charges cited are indication of policy only and are based upon the maximum general admission fee requested upon the patient's initial visit rather than upon the actual amount collected on all occasions. In fact, half of the departments either recorded a definite sliding scale of fees or stated that fees are reduced or remitted entirely whenever the circumstances of the patient require. It is probable that this practice also obtains in most of the other departments, although no statement to this effect appeared on the remaining schedules.

Further analysis, made subsequent to publication of the aforementioned article, reveals that the diversity of fee policy which exists among departments of different medical types is apparently a reflection of the prevailing administrative control over the departments of each medical classification. This conclusion is based upon the fact that a free-admission policy is maintained with relatively greater frequency by special departments which are largely under governmental control, than by general departments which are predominantly operated by non-governmental agencies.

Fee Policy for Special Services

One of the important functions usually performed by an admitting officer is the determination of a patient's ability to pay for prescriptions, laboratory tests, X-ray examinations, appliances and costly drugs such as salvarsan and insulin. The expense of these items may often be a greater burden to patients than the clinic admission fee. This statement applies particularly to those suffering from serious illness of long duration. Consequently, it is a matter of great interest to learn the extent to which out-patient departments either provide these services free on all occasions or remit fees as the circumstances of the patient require.

Because of the necessarily great variation in charges for the services listed, a report of actual fees was not requested. Instead, the departments were asked to check which of the following statements applied: (1) A fee is usually charged. (2) Fees are remitted if necessary. (3) Service is always free. Although there was considerable variation in the number of departments reporting the charge-policy for different services, in each instance a high proportion of the total number submitted information. Therefore, the reporting group probably includes most of the departments which furnish specified services.

It will be observed in Table 2 that fees were most often required for appliances and insulin and were imposed with least frequency for routine laboratory tests. When the proportion of departments in which fees were always charged is compared with the proportion which reported remission of fees, it is found that relatively more follow the latter procedure for each service listed. For example, while approximately one-third of the departments providing appliances and insulin invariably charged for these services, nearly one-half of them waived charges when the occasion warranted; likewise, only eleven per cent of the departments making routine laboratory tests always levy some charge, whereas forty-two per cent refund fees when necessary. A higher proportion of departments remit charges for the use of X-ray equipment than for any other service considered.

Other of the basic data from which Table 2 is drawn suggest that the largest proportion of departments charging no fee is made up of those under local governmental control, whereas relatively few of those connected with non-governmental hospitals recorded this policy. Among the first group of departments, for example, the extremes are represented by seventy-four per cent which charge no fee for routine laboratory tests, and fifty per cent which make free X-ray examinations. In the non-governmental group, on the other hand, the highest percentage of departments rendering free service was thirty-nine for routine laboratory tests. The proportion of non-governmental departments supplying each of the other services without charge fell considerably below this point.

From the material presented in this article it may be concluded that out-patient departments employ a liberal policy in regard to the admission of patients from the standpoint of race and residence. A large number of departments failed to furnish information on socio-economic standards for admission, but of those replying many recognized the need for consideration of medical, social, and economic factors in addition to income, and a few provided detailed outlines of policy. The existence of admission standards community-wide in application was indicated by the reports of departments in a few cities. Finally, the fee policies presented seem to be flexible, and actual charges in a large proportion of the departments appear to be adjusted, when necessary, to meet the circumstances of the patient.

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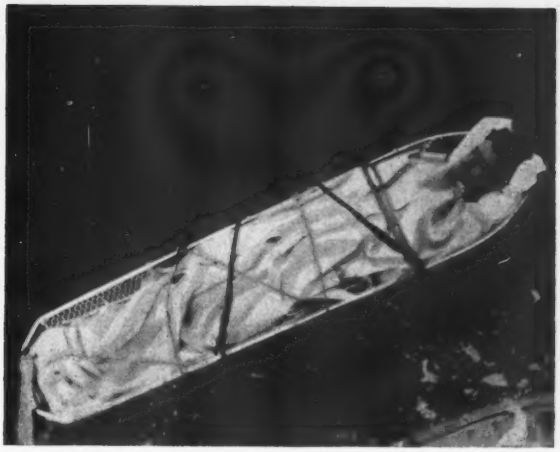
[1] Plumley, Margaret I.:
(a) General Out-Patient Departments, the Important Element in Organized Out-Patient Care, Hospitals, September, 1937
(b) A Count of Visits to Out-Patient Departments Fails to Displose All Ambulatory Care by Hospitals, Hospitals, October, 1937
(c) Location and Characteristics of 769 Out-Patient Departments, Hospitals, December 1937
(d) Income and Expenditures of 174 Out-Patient Departments, Modern Hospital, December, 1937
(e) How Clinic Visits Are Distributed in Out-Patient Departments of Hospitals, Modern Hospital, December, 1937.

[2] See footnote 1d.
[3] See footnote 1c.



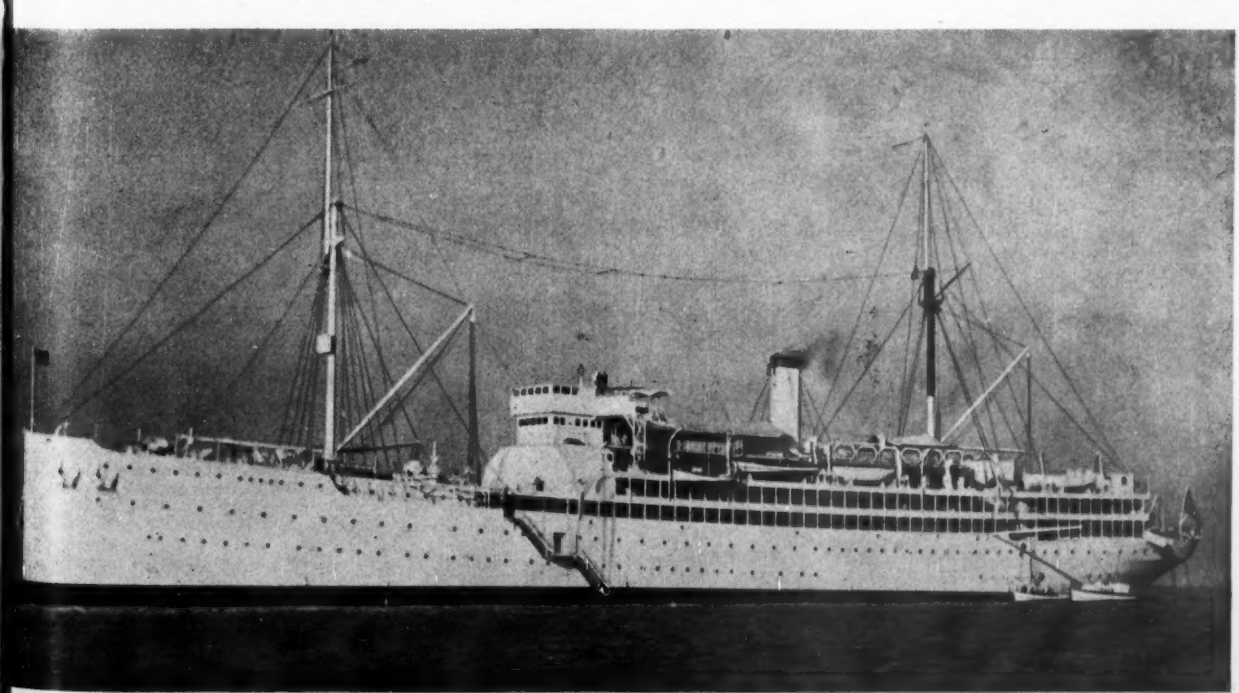
Sea-Going HOSPITAL -- U. S. S. RELIEF

By LUCIUS W. JOHNSON, D.D.S., M.D., F.A.C.S.
Captain, Medical Corps, U. S. Navy

» » » IF YOU WERE ONE of the thousands who visited the U. S. S. Relief, hospital ship of the United States fleet, during the meeting of the American College of Surgeons at San Francisco, or at other ports she has visited, you will probably understand how a hospital can be built into a sea-going ship. Most of our visitors, of whom we had 22,000 in one week at Portland, Oregon, commented on the cleanliness, the good food, the complete equipment and the general air of contentment. The commonest questions were, "Can you do surgical operations at sea?" and "How do you run the hospital?"

The first question is quickly answered. We operate at sea exactly as we do in port or on shore. Only once during the seventeen years of active service of the Relief has it been necessary, so far as I can find, to postpone an operation because of bad weather. That was during a typhoon off Auckland, New Zealand, in 1925. During many years of surgery at sea, I once had to be tied to the operating table to keep me steady while working. That was in the old hospital ship Mercy, off the coast of Oregon, in 1922. One soon comes to accommodate oneself unconsciously to the movement of the ship, and the operating table being firmly secured to the deck gives something solid to brace the operator.

For the second question, "How do you run the hospital?" a little more space is required. We must first explain that there are several types of hospital ships, each of which is planned to perform a different function. There is the fleet hospital ship, which serves as a mobile hospital for a naval unit; the hospital transport, which carries disabled men from a military area to hospitals at home, and rescue ships which act as temporary floating hospitals in time of disaster. The Relief belongs to the first group.



The fleet hospital ship functions like a navy ship with a large sickbay. Maintenance and handling of the ship are looked after by the line officers and crew, the same as on all navy ships. The supply officer provides all ordinary stores, fuel and provisions, and pays all hands. The chaplain looks after the moral and spiritual welfare of the personnel, and arranges their entertainment. The medical and dental officers, nurses and hospital corpsmen care for the patients and maintain the spaces which belong to the medical department

All this is coordinated under definite rules which are laid down in the Navy Regulations, the Manual of the Medical Department and ship's regulations. These provide for nearly all possible contingencies and rarely does a question arise that cannot be settled by reference to the book. The personnel are conversant with the regulations and accustomed to work under them, so all moves as smoothly as in the ordinary hospital on shore.

It may be of interest to glance at the chapter headings of the Ship's Organization and Regulations, U. S. S. Relief. They are:

1. Organization—Policy—Personnel.
2. Berthing and stowage.
3. Messing.
4. Cleaning and Upkeep.
5. Deck space and Assemblies.
6. Divisional Duties and Details.
7. Ship Handling.
8. Routines, Daily, Weekly, etc.
9. Medical Department.
   Administrative Divisions
   Professional Divisions
   Special Divisions; Service Divisions
   Routine Procedures
10. Emergency Drills
    Fire
    Abandon Ship
    Collision
    Fire and Rescue
    Man Overboard.
11. Field and Mobile Emergency Unit.
12. Leave and Liberty.
13. Disciplinary Procedures.
14. Service and Welfare.
15. Communications.
16. General Regulations.

These will suggest to the landsmen many administrative problems that he previously had not imagined.

While the fleet is in port in San Pedro, the Relief remains at anchor in a quiet berth behind the breakwater. When the fleet goes on a cruise, the hospital ship accompanies the other ships of the train. Patients are brought to the ship in boats and carried up the gangway, if in port, or hoisted aboard if at sea.

Special supplies and equipment for the medical department are secured on requisition from the naval medical supply depots at Brooklyn, New York, or Mare Island, California. In case of emergency, any needed items can be procured from local dealers. The Medical Department of the Navy has a supply table which lists several thousand items of equipment and supplies, with allowance tables for each type of navy ship. The hospital ship carries at all times a year's allowance of all supplies except biologicals and perishable articles.

The senior medical officer is responsible for the administration of the medical department, for the care of the patients, and for all the medical department equipment and supplies. There are ten other medical officers including a chief of the medical service, chief surgeon, specialists in eye, ear, nose and throat, urology, laboratory, psychiatry and roentgenology. Three dentists care for the mouths of crew and patients and do the work in the prosthetic laboratory. The three pharmacists take care of the material and stores, the clerical work and the maintenance of medical department spaces.

Nursing is done by a chief nurse and eleven members of the Navy Nurse Corps; also 124 men of the Hospital Corps of the Navy, many of whom hold certificates as technicians in various specialties.

While the rated capacity is 400 patients, at least 500 can be accommodated in an emergency. An elastic capacity is a necessary virtue in a hospital ship, for patients may come in great numbers and in such condition that they cannot be refused. Thus, H. M. S. Soudan, a British hospital ship with a capacity of 302 patients, sailed in August, 1915, from Alexandria for England with 450 sick and wounded on board. During the voyage she was able to rescue 411 survivors of the sinking Royal Edward. With nearly three times as many patients as her rated capacity, she was able to feed, clothe and care for them all.

The operating room of the Relief is large and completely equipped. An excellent test of the surgical facilities was

So much of the traumatic surgery comes from motor-vehicle injuries that this is often spoken of as the motorcycle ward.

Note the hooks on the stanchions to support a second tier of bunks when necessary, also the combination stools and bedside tables hung on the rails of several bunks.

There are two of these large wards, each of which accommodates sixty patients, and also many smaller wards.

provided after the recent gun explosion on the U. S. S. Wyoming when, within a very short time, five operating teams were at work, three engaged in surgery and two giving transfusions. Laboratory, X-ray and physiotherapy equipment are the same as those of large city hospitals.

It may come as a surprise to the landsman to learn that the hazards to the Navy man on shore are much more serious than those at sea. The automobile, the motorcycle and other activities on the beach provide the majority of the injuries. For a hundred years drowning was the principal cause of death in the Navy but, for the last few years, motor-vehicle injuries have led all the rest.

At San Pedro, California, the home port of the larger part of the fleet, there are no naval hospital facilities on shore. The Relief supplies this need. There may be as many as 35,000 men on board the ships present in port, who form the clientele of the Relief. An average year's work represents about 2,500 patients admitted and some 40,000 sick days, 500 major surgical operations, 14,000 laboratory examinations, 6,000 dental examinations and treatments, 5,000 physiotherapy treatments and 1,200 out-patient consultations by the various specialists.

In addition to her seagoing clinical facilities, the Relief carries a complete 66-bed field hospital, which can be set up on shore for duty with an expeditionary force or to aid in relief work in a civil disaster. When Managua, Nicaragua, was leveled by an earthquake in 1931, the Relief was at Panama. The field hospital was loaded into planes and flown to Managua, where it helped greatly in the work of rescue. Again, in 1933, when Long Beach, California, had its severe tremor, the field hospital was set up on shore and played an important part in the relief work. It requires about one hour to get the field hospital, with all its equipment and provisions for three days, out of the hold and into the boats. After they reach the beach, about two hours are required to rig the tents, make up the cots, lay out the equipment and have a hot meal ready for staff and patients.

Hospital ships have been employed for more than three hundred years, but the U. S. S. Relief is the first to be built from the keel up for that specific purpose. Just as a building designed for a hospital would be more satisfactory than an office building taken over for such use, so the Relief is superior to converted merchant ships, which her predecessors have been. Her reputation for skillful

(Continued on page 54)

From top to bottom: A corner of the laboratory on the U.S.S. Relief and the viewing room in the X-Ray clinic. The hospital ship provides consultation facilities for the whole fleet.

Port side of the operating room on the U.S.S. Relief. There is normally space for three operating tables, but as many as five have been in use at once during emergencies.

A corner of the Physiotherapy Clinic where complete equipment is provided for treatment of orthopedic and arthritic patients.

Patient returning to duty, with bag, hammock and necessary papers. Patients returning to duty from a naval hospital must be in all respects ready for any duty at sea, which makes the convalescent stay longer than in civil hospitals.

Prevention of PEMPHIGUS NEONATORUM

By FLORENCE W. HACK, M. D.
Chief of Obstetrical Staff, Women's and Children's Hospital, Chicago
and
RUBY F. DEVEREUX, R. N.
Supervisor, Obstetrical Department, Women's and Children's Hospital, Chicago

» » » PEMPHIGUS NEONATORUM is well known as it affects newborns particularly in hospital obstetrical wards. The majority of writers on pemphigus neonatorum consider that this infection is a contageous epithelial dermatitis, a form of impetigo contagiosa, and that it is either of staphylococcic or streptococcic origin. The disease occurs in endemic form in institutions with a great tendency to become epidemic and goes from one new born to another regardless of the babies' general nutrition and development.

As to whether it may be an eruption of staphylococcic or streptococcic origin may be a matter of great scientific importance; yet to those in charge of newborns, the consideration of greatest importance is that it is a highly contageous disease of the skin, serious in the newborn.

In its prevention, one must eliminate all conceivable origins of both the staphylococcus and the streptococcus. Scrupulous obstetrical cleanliness is just as important in the prevention of pemphigus neonatorum as aseptic technique in surgery; vigorous nursing technique is as valuable as isloation precautions in scarlet fever. Perpetual vigilance is required—isolation of all newborn infants from those in contact with or suffering from infection.

Since 1930, two epidemics have developed in the newborn nursery at the Women's and Children's Hospital—one in the Summer of 1930 and the other in the Spring of 1931. Approximately 30 per cent developed on the first five days of life, 60 per cent on the fifth to sixth days, the remainder on the seventh to the ninth day. About 25 per cent showed in the 12 to 24 hour period previous to the development of the pemphigus lesion, a fine red rash over certain portions of the body. On this location the first pustule appeared. Fifteen per cent had been vomiting and the initial rash appeared around the chin, the neck and upper thorax, two per cent had loose stools and sore buttocks upon which the rash later appeared; 0.5 per cent had slight discharge from the eye prior to the development of pemphigus. Three babies developed abscesses which required incision and drainage; one on the right arm, one on the breast, and one on the scalp.

Occasional cases have developed but no epidemic has occurred since 1931, at which time the following procedures were established:

1. Doctors, interns and nurses who had any focus of infection, or had come in contact with infected discharges were excluded from handling the newborn. Included were sore throats, mild colds, folliculitis, furuncles, paronychia and dermatitis.

2. Only the intern on the clean obstetrical service was allowed to have contact with the newborn.

3. The nurses in the nursery were not allowed to care for any other patients. Relief nurses could not come directly from other floors to work in the nursery.

4. Babies from those mothers who had a skin rash or showed signs of infection of any nature, however mild, on admission to the hospital, were not placed in the newborn nursery.

5. Any mother who developed a temperature was moved with her baby to another place in the hospital.

6. The breasts of mothers who showed slight sign of infection yet not enough for transfer (infected stitches, foul lochia, mild dermatitis, infected heat rash, etc.,) were pumped. The milk was pasteurized and given to the baby.

7. Any baby born outside the obstetrical division of the hospital was not admitted with the newborns.

(Continued on page 53)

In the News

National Hospital Day Committees for 1938

Albert G. Hahn, Chairman, Protestant Deaconness Hospital, Evansville, Ind.

Harvey Agnew, M. D., Canadian Hospital Council, 174 College St., Toronto, Ontario, Canada.

Thomas F. Clark, California Hospital Association, 1182 Market St., San Francisco, Cal.

Graham L. Davis, The Duke Endowment, Charlotte, N. C.

T. R. Ponton, M. D., HOSPITAL MANAGEMENT, 612 North Michigan Ave., Chicago, Ill.

Rev. Edward F. Garesche, S. J., Catholic Medical Mission Board, New York, N. Y.

Mrs. Albert G. Hahn, Protestant Deaconess Hospital, Evansville, Ind.

Maxwell Hahn, United Hospital Fund, 370 Lexington Avenue, New York, N. Y.

H. G. Fritz, Conemaugh Valley Memorial Hospital, Johnstown, Pa.

Clarence C. Hess, Methodist Hospital, Indianapolis, Ind.

M. Ray Kneifl, Catholic Hospital Association, St. Louis, Mo.

Malcolm T. MacEachern, M. D., American College of Surgeons, 40 East Erie Street, Chicago, Ill.

Veronica Miller, R. N., Henrotin Hospital, Chicago, Ill.

Alden B. Mills, Modern Hospital Publishing Co., 919 North Michigan Avenue, Chicago, Ill.

G. W. Olson, Queen's Hospital, Honolulu, Hawaii.

Meta Pennock, "The Trained Nurse and Hospital Review", New York, N. Y.

Mary M. Roberts, R. N., "American Journal of Nursing", New York, N. Y.

Sister Rose Marie, St. John's Hospital, Springfield, Ill.

Sister Mary Reginald, DeSales College, Toledo, Ohio.

Sister M. Stephen, St. Vincent's Hospital, New York, N. Y.

Homer F. Sanger, American Medical Association, Chicago, Ill.

Leonard Shaw, Saskatoon City Hospital, Saskatoon, Saskatchewan, Canada.

Sister Mary Immaculata, Lelia Y. Post Montgomery Hospital, Battle Creek, Mich.

Rev. Clinton F. Smith, Grant Hospital, Chicago, Ill.

Miss Ara Davis, Scott and White Hospital, Temple, Tex.

Ray F. McCarthy, Executive Director, Group Hospital Service, Missouri Theatre Building, St. Louis, Mo.

The State Chairmen for National Hospital Day who have accepted appointees to date are:

Alabama: French H. Craddock, M. D., Sylacauga Informary, Sylacauga.

Arkansas: Raymond Smith, Holt-Krock Clinic, Fort Smith.

California: Rev. T. C. Marshall, Hospital of the Good Samaritan, Los Angeles.

Colorado: Guy M. Hanner, Beth-El General Hospital, Colorado Springs.

Illinois: Victor S. Lindberg, The Swedish-American Hospital, Rockford.

Indiana: Albert H. Scheidt, Indiana University Medical Center, Indianapolis.

Iowa: Verne A. Pangborn, University Hospitals, Iowa City.

Maryland: Gertrude Kramer, West Baltimore General Hospital, Baltimore.

Massachusetts: Joseph P. Leone, Quincy City Hospital, Quincy.

Michigan: Josephine Halvorsen, Port Huron Hospital, Port Huron.

Minnesota: Samuel B. Rice, St. Barnabas Hospital, Minneapolis.

Mississippi: Dr. F. B. Long, Oktibbeha Hospital, Starkville.

Missouri: L. C. Austin, Menorah Hospital, 4949 Rockhill Rd., Kansas City.

Nebraska: H. E. Hess, Nebraska Methodist Hospital, Omaha.

New Jersey: Joseph R. Morrow, M. D., Bergen Pine Hospital, Ridgewood.

New Mexico: Sister Marie Genevieve, St. Vincent Sanatorium, Santa Fe.

North Carolina: Virginia O. McKay, Asheville Mission Hospital, Asheville.

Ohio: Hulda C. A. Fleer, Aultman Hospital, Canton.

Oklahoma: Mrs. D. I. McNulty, Morningside Hospital, Tulsa.

Oregon: Mrs. Marjory Haller, R. N., Doernbecher Memorial Hospital for Children, Portland.

Pennsylvania: H. G. Fritz, Conemaugh Valley Memorial Hospital, Johnstown.

Rhode Island: Henry Joyce, M. D., Rhode Island Hospital, Providence.

South Carolina: Gertrude T. Haynes, Spartanburg General Hospital, Spartanburg.

South Dakota: C. M. Austin, Sioux Valley Hospital, Sioux Falls.

Texas: E. M. Collier, Hendricks-Memorial Hospital, Abilene.

Utah: Mrs. Olive Wardrop, St. Marks Hospital, Salt Lake City.

West Virginia: James W. Harris, Jr., Hospital Association of West Virginia, Kanawha County Library Building, Charleston.

Wisconsin: Margaret Johnson, Beloit Municipal Hospital, Beloit.

THE HOSPITAL CALENDAR

Feb. 28—March 3—Association of California Hospitals, Association of Western Hospitals, San Francisco, Calif.

February 14-15—Council on Education of American Medical Association, Chicago, Ill.

March 9—Massachusetts Hospital Association, Boston, Mass.

April 7-9—Southeastern Hospital Association, Birmingham, Ala.

April 14-16—Virginia, North Carolina and South Carolina Hospital Associations Tri-State meeting, Columbia, S. C.

April 18—Mississippi State Hospital Association, Jackson, Miss.

April 21-22—Midwest Hospital Association, Kansas City, Mo.

April 27-29 — Pennsylvania Hospital Association, Pittsburgh, Penna.

May—Arkansas Hospital Association, Fort Smith, Ark.

May 4-6—Tri-State Hospital Assembly, Chicago, Ill.

May 18-20—New York Hospital Association, Buffalo, N. Y.

May 19-21—Minnesota Hospital Association, Minneapolis, Minn.

June 2-4—New Jersey Hospital Association, Jersey City, N. J.

June 23-24—Michigan Hospital Association, Marquette, Mich.

August 14-16—National Hospital Association, Virginia.

September 23 — American Protestant Hospital Association, Dallas, Tex.

September 25 — American College of Hospital Administrators, Dallas, Tex.

September 26-30—American Hospital Association, Dallas, Tex.

October 17-21—American College of Surgeons, New York, N. Y.

October 25-28—American Public Health Association, Kansas City, Mo.

Wyoming: B. H. Pelton, Jr., 254 South Elk St., Casper.

Washington, D. C.: Mattie M. Gibson. The Children's Hospital, 13th & W. Sts., N. W.

Canada: Leonard Shaw, Saskatoon City Hospital, Saskatoon, Saskatchewan.

Western Institute for Hospital Administrators

» » In conformity with the policy previously announced, the American College of Hospital Administrators will conduct a "Western Institute for Hospital Administrators," to be held at the University Campus, Palo Alto, California, on August 8 to 19. This will be sponsored by the American College of Hospital Administrators, the Association of Western Hospitals and the Association of California Hospitals. The program will be made up of lectures by recognized authorities in specialized fields together with field trips and demonstrations of modern methods in selected approved hospitals.

The lecture subjects will include:

Fundamentals of Hospital Organization; Medical Staff Organization and Relationships; Administrative Problems in Care of the Indigent Sick; Plant Maintenance and Rehabilitation; Nursing Education and Nursing Service; Medical Records; Administrative Aspects of Roentgenology, Pathology and Special Therapy Departments; Hospital Personnel Relations; Organization of the Business Office; and The Future of Hospital Administration.

In the demonstration program recognition is given to the fact that the administrators attending will be specifically interested in different subjects and, in so far as it is possible, students at the institute will be given a choice in selection of hospitals which they will visit.

In the evenings there will be panel round table discussions at which questions brought up by the students will be discussed both from the floor and by selected speakers.

Stanford University is located in one of the most beautiful parts of California and the campus is well adapted to an institute of this type. The hospitals of San Francisco, Berkeley, Oakland and of the cities in the valleys south of San Francisco are easily accessible by public transportation or by private car.

Housing facilities may be had in Lagunita Court, one of the University Dormitories, at the rate of $1.50 per day for single rooms. Meals may be had a la carte or table d'hote at the Stanford Union at the nominal charge prevailing for faculty and students of the University.

Further information concerning the full program, registration and fees will be announced in the near future. All communications concerning the Institute should be addressed to the office of the executive secretary, Association of Western Hospitals, 1182 Market Street, San Francisco, Calif.

Chicago Hospital Council

» » Chicago Hospital Council held its second anniversary meeting at the Congress Hotel on Tuesday, January 18. At 6 p.m. some 350 hospital administrators, trustees and staff members enjoyed a very delightful dinner as the guests of Charles H. Schweppe, president of the Council.

Immediately after dinner Mr. Schweppe, who presided, introduced Arnold F. Emch, Ph. D., the executive director, who very briefly reported on the progress of the Council since its organization, November 26, 1935. The chief accomplishments were:

1. Organization on January 1, 1937, of a Hospital Service Corporation to provide hospitalization for the moderate wage earner. Last reports show a membership of 30,000.

2. Inception of a purchasing service on February 1, 1937. This service is designed to secure more uniform purchasing and decreased costs.

3. Organization of a central credit service on June 1, 1937. This is intended to provide for securing credit information for member hospitals and also for collection of hospital accounts. At the time of the report it was handling $90,000.00 in accounts for member hospitals.

4. Legislative Reporting Service. In collaboration with the Chicago Hospital Association and the Hospital Association of Illinois, a joint committee is watching state legislation and keeping member hospitals informed.

5. Hospital Personnel Relations. Early in the present labor unrest, the Council made a very complete study of personnel relations, formulated a plan of action and distributed this information to all hospitals in the Chicago area, regardless of whether or not they were members of the Council. This was a conservative and constructive piece of work which has received very wide recognition and should be very valuable in establishing permanent harmony in the hospital labor situation.

6. Joint Maternal Welfare Committee of Cook County. This is a committee comprised of all local agencies concerned with maternal welfare. The committee has worked intensively on the problem and is now engaged in drafting for the Department of Health of the City of Chicago, a new set of regulations with reference to the practices and facilities of maternal services.

7. Joint Committee on Public Emergency Ambulance Service. As its name implies, this committee is engaged in formulating and establishing an ambulance service for the city of Chicago, which at the present time has no such public service. The only tangible result at the present time is a decision to provide stretchers for certain of the police squad cars. A careful study of the whole question is being made and without doubt this will eventually result in an efficient system for the city.

8. Coordination of hospital agency efforts. A movement has been commenced having as its objective the coordination of the efforts of all agencies concerned with securing hospital care.

After Dr. Emch's report, Dr. Faxon of Massachusetts General Hospital spoke on the subject, "The Hospital and Laboratory Service." In his brief talk, Dr. Faxon presented one angle of the question of financing laboratory service and while many will not agree with the speaker's opinions, it is only by a calm and unprejudiced study of all points of view that an equitable arrangement will ultimately be reached.

David H. McAlpin Pyle, president of the United Hospital Fund of New York, discussed the recent hospital survey of the city of New York, the situation of private, voluntary and tax supported hospitals of the city and the solution of the problems of each. This monumental survey and such discussions as that of Mr. Pyle will have a great influence in other cities, pointing the way to coordination of effort in both the care of the sick and the means of financing that care.

The last speaker, Dr. Logan Clendening of the University of Kansas, gave the historical background of our present hospital system. His closing satirical description of a patient's day in the hospital emphasized the need for continuing our efforts to increase the humanitarian attitude of the hospital toward the patient.

Association of Western Hospitals

» » Should hospitals occasionally operate on themselves? That is exactly what they are going to do when 2,000 or so hospital administrators and attendants get together in the annual convention of the Association of Western Hospitals and the Western Conference, Catholic Hospital Association in the Fairmont Hotel, San Francisco, February 28 and March 1, 2, 3, 1938.

On Monday, February 28, the subject of how the hospital fits into the community life will be stressed. On Tuesday will come a thorough airing of "Increased Costs of Hospitalization". It will be attacked from many angles, particularly departmental increases, nursing, dietary department, equipment, housekeeping and administration.

The third phase of this exploratory operation will come on Wednesday, March 2, when the increased cost of professional care will be laid open for diagnosis and possible remedies. This cost will be regarded from the standpoint of organized medicine and professional training. A summary will be given by Dr. Malcolm T. MacEachern, Associate Director of the American College of Surgeons. Robert E. Neff, president of the American Hospital As-

sociation, will hold the scalpel over the knotty problem of hospital personnel, and will be aided in both his incisions and his decisions by a number of our foremost co-workers in the medical profession.

Group hospitalization will be the theme for Thursday, March 3, and such outstanding authorities as Dr. L. M. Wilbor, administrator of the San Francisco Hospital, and E. A. Van Steenwyk, director of the Minnesota Hospital Service Association, St. Paul Minn., will be heard. The mounting questions of proper care for patients under industrial agreements, and group agreements otherwise, will be thoroughly gone into.

A general summary of present and pending legislation affecting hospitals will bring the business of the convention to a close on Thursday.

During the four convention days there will be on display 100 commercial exhibits representing every phase of equipment and supplies for hospital operation. This major feature will occupy 12,000 square feet of floor space in the Laurel Court, the Gold and the Red Rooms of the Fairmont Hotel.

In keeping with the atmosphere of the city, the Entertainment Committee has arranged a number of features that will effectually keep the convention from becoming a too-serious affair. The Fairmont Hotel, in which the convention will be held, gives a bird's-eye view of the city and the bay, with the great bay bridge reaching far into the Oakland shore, and the skeleton of Treasure Island, 1939 World Exposition site, quickly filling out and arraying itself in its glittering World's Fair finery. Dinners in Chinatown, visits to Twin Peaks, to Telegraph Hill and to the beautiful East Bay cities, theatres galore, shops that out-Paris Paris, America's stateliest and most beautiful civic center, all await you here.

Coming Meetings

» » The executive committee of the Tri-State Hospital Assembly (Illinois, Wisconsin and Indiana) is actively preparing for its annual meeting in Chicago, May 4, 5 and 6. At a recent meeting it was recommended to the program committee, headed by Doctor MacEachern, that the three major topics be personnel, relations, maintenance of the physical plant and the care of the patient. The obstetrical department, nursing service and the perennial question of the voluntary hospital will also receive special consideration.

The meeting will be held at the Stevens Hotel this year. Nineteen sections will take part and there will be sixteen participating organizations in addition to the three state associations. An especially good exhibit is expected. The program will be of interest not only to administrators but also to trustees and department heads.

The American Protestant Hospital Association is also preparing for its Fall meeting. The place will be Dallas and the time will be immediately preceding the annual meeting of the American Hospital Association. The program will be devoted entirely to problems especially concerning Protestant hospitals, matters of general interest being left for the A. H. A. There is some talk of shortening the meeting to one or two days, instead of the customary Friday, Saturday and Sunday, but this point has not yet been definitely decided.

American Physician's Art Ass'n.

» » The American Physicians' Art Association, a national organization of medical men who have ability in the fine arts, will hold a first national exhibition in the San Francisco Museum of Art, San Francisco, Calif., in June 1938. This exhibition promises to be of unusual interest with entries to be accepted (after jury selection) in the following classifications: oils, watercolors, sculpture, photography, pastels, etchings, crayon and pen and ink drawings (including cartoons), wood carvings and book bindings. Scientific medical art work will not be accepted. The exhibition is not limited to first showings. All entries close April 1, 1938. Any physician interested should communicate at once with the secretary of the American Physicians' Art Association, Suite 52-536, Flood Building, San Francisco, Calif.

Duval County Hospital

» » The governing Board of Duval County Hospital, Jacksonville, Florida, is asking the Federal Works Progress Administration to approve a project which contemplates extensive additions to present facilities. Detailed plans, which have been completed, provide a connecting unit of reinforced concrete and stucco with a surface basement and three upper floors. It conforms in design to the hospital's present style of architecture.

In connection with this new construction, it is anticipated that 150 to 165 beds may be added to present capacities, making a total of approximately 400 beds. Total costs are estimated at $257,500.00.

This project has received the approval of all local and State authorities and of Florida's Senators in the United States Congress.

Successful Group Hospitalization

» » The merits of the associated hospital service plan of Boston which began to operate last September, are strongly indicated by the experience of the first four months. The quota set for membership by Christmas was 3500. The total reached more than 10,000. Practically all the best hospitals of the state are cooperating, including twenty-eight in Boston and seventy-three elsewhere. Groups, which are the unit of membership, have been formed in 101 business plants. All the expectations of the Boston men who launched the project have been realized.

A.M.A. Approved Lists

» » The American Medical Association has issued as reprints its lists of hospitals approved for internships and for residencies in specialties. In addition, the association has also issued lists of schools approved for training of clinical laboratory technicians and physical therapy technicians.

These are reprinted from the Journal of the American Medical Association, August 28, 1937, and may be secured from the office of the Association, 535 North Dearborn Street, Chicago.

New Houston Hospital

» » Houston, Tex., will have hospital facilities second to none with the $2,500,000 city-county charity institution and the $700,000 addition to St. Joseph's Infirmary completed next Spring.

The new Jefferson Davis Hospital is a 500-bed institution for free patients only. This brand new, beautiful plant, located on a hill overlooking winding Buffalo Bayou, is in sharp contrast to the old Jefferson Davis Hospital. The old Jefferson Davis is crowded when 200 patients are jammed into it, and often the beds were placed in the hallways.

Completion of the maternity and children's building at St. Joseph's Infirmary will greatly enlarge the capacity of that institution. With the completion of this impressive, ultramodern unit, St. Joseph's will have 350 beds, the largest private hospital in the city.

Simplified Practice Recommendation

» » The Bureau of Standards, U. S. Department of Commerce, has released Simplified Practice Recommendation R 24-37, referring to hospital beds. This recommendation specifies length, width and height of the bed and, along with other information, lists those who have accepted the recommendation.

Bigger Load Seen on State Hospitals

» » The State Board of Control of Wisconsin is finding that demands upon mental hospitals are increasing despite a slight lowering of the daily average. It is reported that there has been a steady increase in the number of first

admissions. Of these the number of voluntary admissions has increased 35 per cent.

Detroit Hospital Survey

» » The Jewish Welfare Federation of Detroit has undertaken a hospital survey for the purpose of determining whether there is a need for a hospital under Jewish auspices in Detroit. For this purpose it has invited Dr. J. J. Golub, director of the Hospital for Joint Diseases of New York City, to direct the survey.

In outlining the purposes of the survey, Dr. Golub states that the study will be guided by the following four principles:

"1. Is the need in hospital service as a whole greater than that which the available services can give?

"2. Is there a need for a hospital for any special service which is not being furnished?

"3. Is there a need for additional and not now readily-available opportunities for staff appointment for Jewish physicians and interns to enable them to keep abreast of the progress in medical science and to pursue research?

"4. Is there a need for creating an agency to encourage the wider use of existing health agencies, since many people are unaware of their existence and the character of their work?"

The survey will involve considerable fact-finding procedures, and correlation and interpretation of data. It will also concern itself with the educational opportunities and hospital staff appointments of physicians of Detroit.

Nurses Given a Choice

» » The health committee of the grand jury of Los Angeles has recommended in its final report that the nurses, who are victims of infantile paralysis, be given the privilege of going to the Milton H. Berry Institute of Paralysis Correction at Van Nuys. Heretofore treatment of these women, some 100 of whom still are paralyzed, has been confined to various hospitals and rest homes, many of which lacked facilities for attempting to rehabilitate the victims, who are in no sense sick but merely incapacitated by muscular conditions.

PERSONALS

● JOHN B. FRANKLIN, superintendent of Grady Hospital, Atlanta, Ga., has accepted the directorship of the John D. Archbold Memorial Hospital, effective Mar. 31.

● MRS. GRACE P. WALLER, superintendent of nurses at the Iroquois Hospital, Watseka, Ill., is leaving that institution. On March 1, she will assume the position of superintendent of the new City Hospital at Little Rock, Ark. MISS OPAL NEWMAN will succeed Mrs. Waller at the Iroquois.

● The appointment of ANDREW F. BARNETT, M. D., as managing officer of the Anna State Hospital, Springfield, Ill., to succeed R. A. Goodner, M. D., who died recently, has been approved by the Governor.

● MRS. DOROTHY BRACKEMEYER has been named general superintendent of the Morrison Hospital, Morrison, Ill., to fill the vacancy caused by the resignation of Irene Irion.

● JOHN MEDEARIS of Centerville has been named by the county commissioners to succeed JAMES L. MAY as superintendent of the Wayne County Infirmary, Richmond, Ind.

● MISS MARY R. McCARTHY has been appointed supervisor of nurses to succeed Mrs. Susan B. Nicholson, who died recently, at the Burke Memorial Municipal Hospital, Lawrence, Mass.

● W. C. TISDAL, M. D., will succeed J. A. Land, M. D., of Hobart as superintendent of the Western Tubercular Sanitarium at Clinton, Okla.

● M. W. KEMP, M. D., head of the Anoka State Hospital, Anoka, Minn. has been appointed superintendent of the new Moose Lake State Hospital for the Insane. WALTER P. GARDNER, M. D., will succeed Dr. Kemp at Anoka.

● FRANK SMITH has been named business manager of the Western Oklahoma Charity Hospital at Clinton by the State Board of Affairs. Dr. H. K. SPEED, JR., was recently named medical superintendent of the new hospital.

● ROY ALEXANDER, formerly manager of the McLain Rogers Hospital at Clinton, Okla., has been appointed manager of the Morningside Hospital, Tulsa.

● The board of directors of the Black Hills Methodist Hospital, Black Hills, S. D., have announced the resignation of REV. R. E. RICH, superintendent of the institution. His successor has not yet been named.

● SISTER M. CORNELIA has been appointed Sister Superior at St. Mary's Hospital, Oshkosh, Wis. She is succeeding SISTER M. IMMACULATA, who has been transferred to Milwaukee. SISTER M. MELANIE, who has been the superior at St. Mary's Hospital at Roswell, N. M., is replacing Sister Cornelia at Stevens Point, Wis.

● GEORGE H. CONKLIN, M. D., superintendent of the Middle River Sanatorium, Superior, Wis., for the past four years, has announced his resignation. His successor has not yet been named.

● MISS ABBY P. CHOATE, R. N., a graduate of Massachusetts General Hospital, has been appointed superintendent of nurses at Seaside Hospital of St. John's Guild, Staten Island, New York. Miss Choate succeeds Miss Lorraine Setzler who has accepted a call to Iran to establish schools of nursing in that country.

● MISS ELIZABETH K. FOOTE left Mount Sinai Hospital of Philadelphia on January 15, to take her new position as assistant director of nursing at the Presbyterian Hospital, Porto Rico, West Indies. Miss Foote is a graduate of Rome Hospital, New York. She received her A. B. degree at Teachers College, Columbia University, in 1934, and then assumed her duties as director of nursing at the Mount Sinai Hospital.

● ALBERT C. SEAWELL, manager of collections at Baylor Hospital, Dallas, Tex., for three years, will succeed Lawrence R. Payne, as assistant superintendent of the hospital.

● After many years of efficient service, GEORGE H. CONKLIN, M. D., of Douglas County Sanatarium, Superior, Wis., has retired.

PROJECTS

● The Board of managers of the State Hospital, Benton, Ark., has authorized the State Construction Commission to proceed with plans for construction of four new buildings at the Benton unit. The plans provide for a 50-bed tuberculosis cottage for women, administration building, superintendent's home and canteen. Bids were asked in January. $70,000 is available for the improvements.

● The Helena, Ark., Hospital Board applied to the Commonwealth Fund of New York for a $260,000 appropriation for the construction of a 63-bed hospital. The hospital board would furnish $40,000.

● The Veterans' Administration opened bids on February 8 for construction of additional buildings at the Bay Pines Veterans' Facility, Bay Pines, Fla. The plans provide for one hospital building, guard house and storehouse with connecting corridor.

● Florida's first tuberculosis sanatorium has been officially opened at Orlando. The new building, when completely equipped, will cost approximately $700,000.

● The WPA has started work on a $35,855 clinic building in Tampa, Florida. The building will be two stories high, 50 by 100 feet. The city will furnish $21,919; the WPA is to supply the remainder. M. Leo Elliott, 415 Tampa Street, Tampa, is the architect.

● The Galloway Hospital, Anthony, Kansas, was badly damaged by fire recently. The X-ray equipment was destroyed, as well as many other furnishings. The amount of the loss was undetermined.

● A contract has been awarded to the National Concrete Construction Co., for additions to Ss. Mary and Elizabeth Hospital at Louisville, Ky. The new building, to be 52 by 200 feet and four stories high, will contain an obstetrical department, operating rooms and added treatment facilities.

Dietary and Food Service

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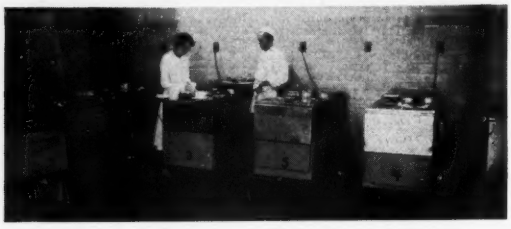
Section of the large, well equipped central diet kitch n.



Partial view of the battery of 18 Ideal Food Conveyors on regular duty here at the General Hospital.

Serving 130,000 to 140,000 "kitchen-hot" meals a month—smack on the stroke of each meal time—is mo.e than an ordinary task in this great state institution. Its 800-bed theoretical capacity (675 patients, on average, served by conveyor method) is confined to 4 floors. Horizontal distances are extensive. Yet, every patient, no matter how far situated from the central diet kitchen, receives a delicious, piping-hot meal—food kept right at the proper serving temperature, as hot as if it were served at the kitchen table. Meal service is concluded within a brief 20-minute period. The Iowa State University General Hospital uses 18 Ideal Food Conveyors. The first were installed over ten years ago. Not until recently, after 10 years constant usage, was there need on a single one of them for even minor repairs. A tribute to the built-in durability and dependability of Ideal equipment.

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DIETARY AND FOOD SERVICE

MARGARET ROSENMEIER
Dietitian, Henrotin Hospital, Chicago, Ill.
EDITORIAL DIRECTOR

THE STORY OF COFFEE

By MARGARET ROSENMEIER
Dietitian, Henrotin Hospital, Chicago, Ill.

» » » "IT IS REMARKED by several learned men," wrote R. Bradley, a Fellow of the Royal Society, in 1721, "that coffee is of excellent use in the time of pestilence, and contributes greatly to prevent the spreading of infection. And one of them observes that in some parts of Turkey where the plague is almost constant, it is seldom mortal in those families who are rich enough to enjoy the use of coffee, but that the poorer sort who want that benefit seldom escape." Such was the observation made in the eighteenth century on the value of coffee. Today we do not give this beverage the credit for preventing the spread of disease, but we do give it a foremost place in our daily dietaries. We know that in a hospital there is no one item which receives the praise or condemnation coffee receives. A cup of good coffee is a requisite for starting the day right. A person might forget a poorly prepared meal, but he never forgets a cup of bad coffee.

Coffee grows wild in tropical Africa and has been cultivated in many tropical regions in the eastern and western hemispheres. The variety most commonly grown for commercial use is "Coffea Arabica". When this seed is planted in different soils, altitudes and climates, it takes on different characteristics. This is the reason coffee grown in Brazil, Columbia, Venezuela, etc., differs from one another in both flavor and appearance. The finest crops are raised in the high altitudes of Columbia. The full richness and mellow flavor of blends of Columbian coffee is apparent to all connoisseurs of this beverage. Also, Columbian coffees have the outstanding feature of being economical as they contain such a concentrate of flavor and aroma that a smaller amount can be used than is necessary of the weaker varieties.

The flowers grow in clusters against a branch where the stems of the leaves grow. These blossoms are white and in damp countries the blossoms may appear three times during the year. In fact, a tree may have blossoms, green berries and ripe berries at the same time. In dry countries, there is only one blossoming season. In about seven or eight months the cherry develops. This is green at first, but becomes a reddish black when fully ripe. The outside hull contains a sweet gelatinous pulp which covers two oval beans rounded on the outside. There are several outside coverings which are removed before roasting.

Photograph on departmental cover, courtesy American Can Co.

When the coffee berry is ripe, it is usually picked by hand so as not to harm the unripe berries.

The coffee is sent to America green where it is sold to the coffee merchants. Experts judge it first by appearance and next by roasting, grinding and tasting the sample. The expert knows at a glance the country of the origin of the various green beans. He also knows the advantage of each variety and the best blends for each. All of the coffee on the market today is blended.

After careful mixing, the product is ready for roasting —a fine, delicate task. Only experts, with long experience, are entrusted with this work. The roasts of coffee are classified according to the degree to which the beans have been submitted to the process. They are: (1) Light, (2) Medium, (3) Dark, (4) Italian or French. Usually the medium roast is used in the United States. The French or Italian is used in the southern countries. If a bean were roasted more than the Italian, it would be carbon.

Green coffee has practically none of the coffee flavor and aroma. It is the roasting which develops the aromatic oil, fixed oil and carbon dioxide gas. The carbon dioxide gas exerts more than fifty pounds of pressure per square inch inside the roasted coffee bean, and when the roasted bean is ground, the gas escapes with such force that 65 per cent of it disappears in twenty-four hours. In nine days almost all of the gas has escaped.

The aromatic or volatile oil is that which contains the aroma or flavor of the coffee. This escapes along with the carbon dioxide gas. Roasted coffee also contains about two ounces of a fixed oil per pound. This does not leave the bean.

Oxygen of air is one of the greatest enemies of coffee as it unites with the substances and forms a disagreeable flavor which we call staleness. Therefore, roasted and ground coffee exposed to the air for a week has lost 50 per cent of its freshness, and in fifteen days it loses 75 per cent. Because of this it is important to have freshly ground coffee at all times. If possible, it is advisable to

(Continued on page 36)

Steamed Salmon Pudding

Salmon Chalupas

CANNED SALMON ON LENTEN MENUS

By HELEN ASHCRAFT

» » » LENTEN MENUS have a perfect right to be repetitious if they can manage not to seem monotonous. It is a challenge to the inventiveness of the meal planner, for the task of bringing routine hospital diners contentedly through this symbolical forty-day period before Easter is a very real one.

Many meatless days must be observed and fish, the first food of the season, must be served again and again. So must all the various meat substitutes. Meanwhile, the eye is on the budget as usual and the diversified tastes and fancies of the dining staff strictly on the conscience. A challenge it is.

Exploring the many cornered food world for the illusive "something different" becomes fairly urgent during this time. With emphasis being placed on meatless main dishes and on sea foods in particular the path to the fresh fish market is apt to become all too familiar and well beaten. When this happens it is time to explore new fields for fresh inspiration. Certain fish foods in canned form may "go institutional" at the slightest encouragement and be concocted into many tempting dishes. They will certainly widen the range of choice and make possible many heartening economies too.

Of these, canned salmon will want special attention during this struggle to be ingenious though repetitious. There are a great many things to be done with salmon. It has a kind of "mingleability" all its own and is utterly companionable with all the favorite extenders. And since, of course, it is a ranking protein food it is well suited for use as the main dish and it is always substantial and satisfying in that role.

An excellent steamed fish pudding may be made with salmon and to look as appetizing as it tastes.

Steamed Salmon Pudding

The proportions to a one pound can of salmon are:

1 tablespoon butter	1 teaspoon salt
1 tablespoon flour	1 small minced onion
½ cup scalded milk	1 teaspoon parsley
½ teaspoon mustard	2 beaten eggs
½ cup bread crumbs	¼ cup butter

Remove skin and bones from salmon and flake it. Follow the general rule for the steam pudding. Serve with lemon slices and anchovy or tartar sauce.

And here are other suggestions. Most of them may be varied, tasted and tested to suit.

Salmon Dumplets

Make a good rich biscuit dough, roll out to quarter inch thickness and cut into four-inch squares. Clean one pound canned salmon and flake it. Mix with one cup chopped fresh mushrooms which have been simmered in butter.

Allow about one-half cup mixed salmon and mushrooms to each square of dough. Fill and pinch corners and edges of dough together, first sprinkling with lemon juice and a little minced parsley.

Bake quickly and serve with sauce made as follows:

Cheese-Lemon Sauce

2 tablespoons butter	¼ pound nippy cheese, cubed
1 tablespoon flour	½ teaspoon salt
1 cup top milk	½ teaspoon mustard
2 tablespoons lemon juice	

Blend butter, flour, milk and cook till smooth. Add cheese and stir till melted. Add other ingredients and stir well. Serve one tablespoon to each dumplet.

Salmon Chalupas

1 cup cornmeal	1 beaten egg
1 cup boiling water	½ pound canned salmon
1 teaspoon salt	½ cup grated cheese

Stir cornmeal into the boiling water after the water is removed from the fire. Add the beaten egg and the flaked salmon from which skin and bones have been removed. Form into patties and fry in hot fat. When brown sprinkle with grated cheese and place a few seconds under flame till cheese is melted. Serve with onion slices and this sauce:

Mexican Sauce

4 tablespoons butter	¼ teaspoon all spice
2 tablespoons flour	1 finely minced onion
2 cups tomato puree	Salt and pepper

Brown onion in butter. Add the flour and spice and stir in the tomato puree. Simmer and serve when slightly thickened.

Salmon Irlandaise

For one pound can salmon, well cleaned and flaked add:

12 fresh oysters, chopped	1 cup bread crumbs
Chopped parsley	2 tablespoons melted butter
	1 egg

Mix and form into loaf. Bake about 30 minutes in a moderate oven. Serve with tartar sauce.

Casserole of Salmon

Combine ¾ pound canned salmon with:

1 cup medium cream sauce
½ cup cooked diced celery
½ cup cooked new peas
1 small minced onion
Salt, pepper

Mix well. Place in buttered casserole. First bake about 10 minutes in a hot oven, then remove and top with tiny unbaked biscuits. Return to oven until biscuits are baked.

Curried Salmon with Rice

To a pound of canned salmon, flaked and cleaned, add:

2 cups cooked, seasoned rice
1 teaspoon curry powder blended in butter
2 cups thin white sauce
Chopped, cooked mushrooms if desired.

Mix well and turn into buttered baking dish. Dust with paprika. Bake in moderate oven.

Salmon Newburg with Vegetables

1 pound canned salmon
1 cup Newburg sauce
Whole cooked mushrooms
Parsley
Small cooked onions, whole
Cooked carrot balls
Whole cooked beets

Clean and flake salmon. Combine with Newburg sauce. Heat thoroughly. Place portions on hot serving plates and surround with mushrooms and vegetables which have been well buttered and seasoned. Garnish plates with parsley.

Salmon Hollandaise

To be served very hot in patty shells.

¾ cup butter
4 egg yolks
Juice of 1 lemon
¾ cup boiling water
1 pound canned salmon
½ teaspoon salt
⅛ teaspoon paprika
Dash cayenne
1 cup cooked new peas

Make sauce and add cleaned, flaked salmon and the peas. Taste for seasoning.

Baked Noodles Yukon

Make sauce with:

2 tablespoons melted butter
1 tablespoon flour
1 teaspoon salt
1 cup warm milk

Mix with 2 cups cleaned, flaked salmon. Fill buttered casserole with alternate layers of salmon and cooked noodles, sprinkling each layer well with buttered bread crumbs. Bake in moderate oven about 30 minutes. Again mushrooms may be included if desired.

New York Hospital To Have Field Practice Course

» » A field practice course for graduate dietitians will be conducted at the New York Hospital from July 6 to August 13, 1938, under the direction of Miss Margaret Gillam. This course offers observation and experience in the management of food service in the institution. The administrative course includes food ordering, purchasing, food stores control, use of quantity recipes, food accounting, payroll analysis, control of supplies and equipment inventories. Practical experience is provided in the three kitchens and nine dining rooms in which about six thousand meals are served daily. About one-half of the time is given to the study of diet in relation to disease. A series of lectures and clinics is being arranged by physicians on the staff of the New York Hospital and Cornell Medical College.

Margaret S. Gillam of the New York Hospital or Mary de Garno Bryan of Teacher's College, Columbia University, New York City, will be able to furnish additional information concerning the course.

"I must do something to keep my thoughts fresh and growing, else I have no intelligent message for my fellow man."

—JAMES A. GARFIELD
20th President of the United States

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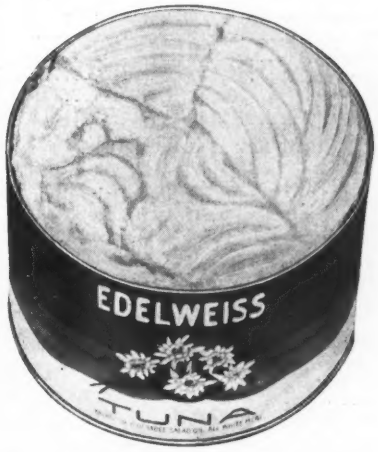

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SEXTON QUALITY FOODS

J. S. & Co., February, 1938

Food Prices Drop Slightly in December

» » December food purchase prices decreased .79 per cent as compared with November 1937 price levels, according to the latest Grinstead Food Price Index, compiled monthly by R. M. Grinstead & Company, Inc. of New York City. The December index was 125.58 as compared with 118.15 in December of a year ago, being an increase of 6.28 per cent this December over last December.

Poultry, vegetables, salads and dairy products are the only groups that increased over November levels. All groups except fish, vegetables and dairy products show a marked increase over December, 1936 levels. Although meats decreased 2.42 per cent under November levels, they are still 16.21 per cent above last December. Poultr increased .24 per cent over November and 18.43 per cent over December of last year. Seafood decreased from November 3.46 per cent and also decreased 3.37 per cent under the December 1936 index. Vegetables increased 3.43 per cent and salads increased 3.45 per cent over the November index for these groups, while vegetables decreased 11.27 per cent and salads increased 10.62 per cent over the group levels for December, 1936. Although fruits decreased 7.64 per cent under November levels, this group is still 5.99 per cent higher than last December. Dairy products increased slightly over the previous month, but are 7.67 lower than December of last year.

Evaluating the weighted average of food prices paid in January, 1934 at 100, the course of price changes has been as follows:

January, 1934	100.00
December	118.15
January, 1937	122.12
February	121.63
March	123.89
April	122.44
May	121.04
June	120.77
July	124.61
August	124.71
September	129.44
October	127.77
November	126.57
December	125.58

The following table shows in percentages, the average change in December from the preceding month and from December, 1936. The proportion of the main food groups purchased last month is shown in percentages of expenditures

Prices paid in December, 1937, compared to:

	Nov. 1937	Dec. 1936	December 1937 Percentages of Expenditures
Meat	−2.42%	+16.21%	25.20%
Poultry	+ .24	+18 43	12.11
Seafood	−3.46	− 3.37	6.22
Vegetables	+3.43	−11.27	6.47
Salads	+3.45	+10.62	2 14
Fruit	−7.64	+ 5.99	2.74
Dairy Products	+ .06	− 7 67	23.74
Groceries	− .26	+ .09	21.38
Change on Total (Weighted)	− .79	+ 6.28	100.00

Keep track of price changes by watching this Index, which appears Every month exclusively in HOSPITAL MANAGEMENT.

Ice Cream for Small Plants

ICE CREAM FOR SMALL PLANTS. By Etta H. Handy. John Willy, Inc., 950 Merchandise Mart, Chicago, Ill.

This book opens up to small hospitals and hotels a way to serve ice cream at a nominal cost. It gives a detailed explanation of making ice cream and frozen desserts and the computation of the profit concerned. Each of the thirteen chapters deals with a different phase of ice cream making. The book includes about seventy-five pages of recipes and twenty-three pictures of specialty dishes.

Miss Handy, the author, is a dietitian whose specialty is the manufacture of ice cream, and she is well versed on the subject about which she writes.

Correction

» » In the January issue of HOSPITAL MANAGEMENT in the Dietary and Food Service Section, edited by Margaret Rosenmeier, appeared an article entitled "Silverware—Its Purchase and Care". The material for this article was supplied by the International Silver Company and the basis for it was a paper delivered by A. A. Schipke of that company before the International Stewards' Association meeting held in Philadelphia in August 1937. HOSPITAL MANAGEMENT regrets that proper credit was not given to Mr. Schipke and hastens to make this acknowledgement.

Coffee . . .

(Continued from page 33)

have a fresh shipment daily. However, not everyone is able to buy coffee daily, and to aid these people the vacuum pack was introduced. The coffee is put into the can roaster-fresh and the air is removed. The can is then hermetically sealed. Like other coffee, this should be used within ten days after the can has been opened.

Regardless of the quality of the product purchased, a good cup of coffee cannot be insured unless every precaution is taken in its making. There are several ways of doing this: drip method, percolating and boiling. Each institution has its own requirements to meet and the method of making is of little concern if certain rules are followed:

1. Be sure that the grind and roast are best suited to your needs. Inform your coffee salesman of your needs and entrust him with the responsibility of giving you the proper kind.

2. Make sure all of the water has been removed from the coffee maker after each meal and start with fresh water.

3. Do not allow the water to come into contact with the grounds until it is boiling furiously. Any temperature less than boiling will not make really good coffee. Do not use water that has been boiling for a long time.

4. Make sure that all measurements are accurate.

5. Last, but not least, be sure that your coffee urn is absolutely clean. Do not use dirty coffee bags and keep them in cold water when not in use. Do not wash the bags with soap. Coffee sediment sticking to the pot gives a musty stale taste to the finished product.

MENUS FOR THE PERSONNEL

In response to many requests, we are this month publishing menus for the personnel instead of the customary patients' menus.

Breakfast	Lunch	Dinner
	Tuesday, March 1	
Apricot Juice Oatmeal Scrambled Eggs Bacon Toast	Macaroni & Canadian Cheddar Cheese Chopped Vegetable Salad Canned Peaches Cookies	Roast Leg of Lamb Mint Jelly Mashed Potatoes Julienne Carrots Stuffed Baked Apple
	Wednesday, March 2	
Stewed Prunes Cornflakes Bacon Raisin Toast	Hamburger Patties on Toasted Buns French Fried Potatoes Cole Slaw Fruit Jello	Old Fashioned Meat Pie with Vegetables Tomato Salad Farina Pudding with Nutmeg Sauce
	Thursday, March 3	
Nectarines Ralstons Poached Eggs on Toast Breakfast Roll	Baked Beans with Pork Lettuce with 1000 Island Dressing Gingerbread	Pot Roast of Beef Steamed Potatoes Buttered Onions or Fresh String Beans Tapioca Cream
	Friday, March 4	
Canned Strawberries Pettijohns Fried Eggs Toast	Spanish Omelet Buttered Broccoli Stuffed Celery Salad Bran Muffins Apple Butter	Meat Loaf or Broiled Blue Fish Parsley Potatoes Creamed Peas Cherry Pie
	Saturday, March 5	
Stewed Apricots Omar Cereal Bacon Toast	Ham a la King Baked Potato Chopped Vegetable Salad Fresh Apple Sauce	Breaded Veal Cutlets Mashed Potatoes Stewed Tomatoes Cottage Pudding with Lemon Sauce
	Sunday, March 6	
Half Grapefruit Shredded Ralstons Sausages Coffee Cake	Beef Rib Roast Browned Potatoes Fresh String Beans Spiced Prune Salad Macaroon Ice Cream	Oyster Stew Chicken Salad Sandwiches Fresh Fruit Cup Plain Cookies
	Monday, March 7	
Pear Juice Wheaties Soft Boiled Egg Toast	Chop Suey with Chinese Noodles Steamed Rice Lettuce with French Dressing Chocolate Frosted Doughnuts	Baked Spareribs Potatoes and Carrots Mixed Fruit Salad Bread Pudding
	Tuesday, March 8	
Sliced Oranges and Bananas Rice Crispies Bacon Toast	Corn Fritters with Grilled Bacon Fruit in Jello Salad Caramel Blanc Mange Pudding	Chicken a la King on Toast Shoe String Potatoes Buttered Peas English Apple Pie
	Wednesday, March 9	
Pineapple Juice Cream of Wheat Sausage Patties Toast	Italian Spaghetti Head Lettuce Salad Sliced Oranges	Broiled Liver Au Gratin Potatoes 7 Minute Cabbage Peach Cobbler
	Thursday, March 10	
Stewed Prunes Wheatena Shirred Eggs Toast	Creamed Dried Beef on Pancakes Chopped Vegetable Salad Baked Apple	Stuffed Breast of Veal Buttered Noodles Harvard Beets Jelly Roll
	Friday, March 11	
Canned Grapefruit Omar Cereal Pancakes with Maple Syrup	Scrambled Eggs and Cheese on Tea Biscuits Cooked Vegetable Salad Baked Apple	Roast Pork, Cranberry Sauce or Salmon Croquettes Mashed Potatoes Buttered Peas Date Torte
	Saturday, March 12	
Sliced Bananas Oatmeal Bacon Toast	Vegetable Plate with Baked Squash Spinach Deviled Egg Rice Croquettes Fruit Salad Prune Whip Custard Sauce	Lamb Patties Creamed Potatoes Diced Carrots Lemon Fluff Pudding
	Sunday, March 13	
Orange Juice Ralstons Broiled Ham Cinnamon Toast	Fricasse of Chicken, Dumplings Spiced Fruit Mashed Potatoes Buttered Cauliflower Peppermint Ice Cream	Cream of Tomato Soup Fruit Salad and Cheese Plate Nut Bread
	Monday, March 14	
Kadota Figs Farina Scrambled Eggs Toast	Cold Sliced Tongue Stuffed Baked Potatoes Perfection Salad Crumb Muffins and Peach Preserves	Swiss Steak Steamed Potatoes Stewed Tomatoes Chocolate Cake with Chocolate Sauce
	Tuesday, March 15	
Tomato Juice Mead's Cereal Bacon Sweet Rolls	Frankfurters Hot Potato Salad Peach and Cottage Cheese Salad	Leg of Veal Mashed Potatoes Buttered Spinach Cherry Cobbler
	Wednesday, March 16	
Half Oranges Rice Flakes Fried Corn Meal Mush with Maple Syrup	Lamb Stew with Peas, Onions & Potatoes Corn Bread Carrot Strips Lemon Snow Pudding	Baked Ham Baked Sweet Potatoes Buttered Lima Beans Pineapple Upside Down Cake

HOSPITAL MANAGEMENT'S DIETARY AND FOOD SERVICE DEPARTMENT

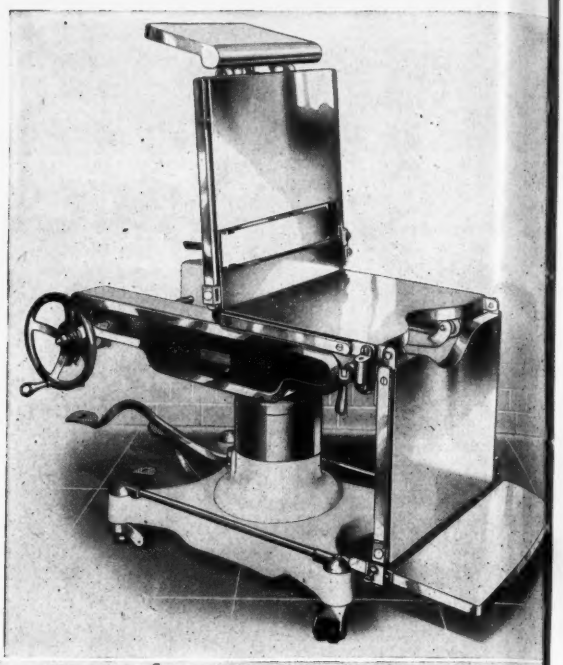
MENUS FOR THE PERSONNEL

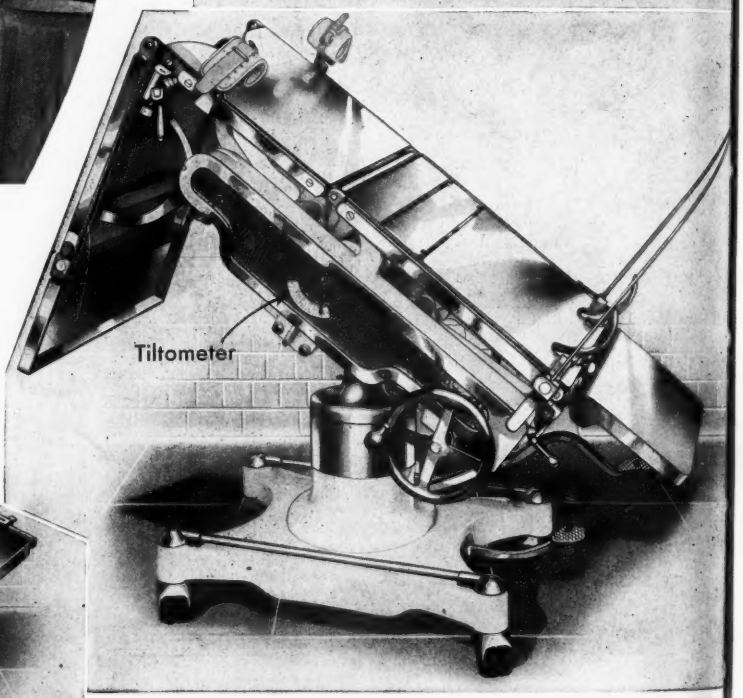
Continued

Breakfast	Lunch	Dinner
	Thursday, March 17	
Fresh Grapefruit, Emeraldettes Ralstons Scrambled Eggs Toast	Creamed Hamburger on Toast Broccoli Minted Pineapple Salad Pistachio Ice Cream	Lamb Chops Mint Jelly Parsley Potatoes Buttered Peas Stuffed Green Pepper Salad St. Patrick Cakes
	Friday, March 18	
Stewed Prunes Oatmeal French Toast with Jelly	Open Faced Toasted Cheese Sandwich Potato Chips Chopped Vegetable Salad Sliced Bananas in Grape Gelatin	Fried Boneless Perch with Tartar Sauce Mashed Potatoes Red Kidney Beans Rice Pudding and Raisins
	Saturday, March 19	
Stewed Apricots Cream of Wheat Sausages Toast	Manhattan Meat Roll with Vegetable Gravy Fresh Fruit Salad Pecan Rolls	Short Ribs of Beef Steamed Potatoes Broiled Tomatoes Date Nut Blanc Mange
	Sunday, March 20	
Sliced Oranges Cornflakes Poached Egg on Toast Breakfast Rolls Jelly	Pork Chops Stuffed with Apples Mashed Potatoes Sautéd Corn, Pimientoes Ice Cream with Chocolate Sauce	Cream of Potato Soup Tomato & Lettuce Salad Nut Cake
	Monday, March 21	
Prune Juice Pettijohns Bacon Toast	Chili Con Carne Head Lettuce Salad Bismarcks	Smoked Ham Butts Steamed Potatoes Sauerkraut Banana Cream Pie
	Tuesday, March 22	
Tomato Juice Wheatena Fried Scrapple Toast	Escalloped Macaroni and Dried Beef Chopped Vegetable Salad Blue Plums	Boiled Beef with Mustard Browned Potatoes Creamed Rutabagas Charlotte Russe
	Wednesday, March 23	
Tangerines Shredded Wheat Fried Eggs Toast	Ham Loaf with Horseradish Sauce French Fried Potatoes Spiced Beet Salad Apple Snow Pudding	Roast Veal Shoulder Steamed Rice Carrots with Lemon Butter Norwegian Prune Pudding
	Thursday, March 24	
Apple Sauce Oatmeal Bacon Toasted English Muffins Jelly	Scrambled Eggs and Brains Baked Potato Wilted Lettuce Fruit Compote	Lamb Neck Slices Mashed Potatoes Creamed Celery Cabbage Banana Fritters
	Friday, March 25	
Grape Juice Ralstons Fried Corn Meal Mush with Jelly	Spanish Rice Watercress and Egg Salad Fruit Tapioca	Vegetable Plate with Creamed Mushrooms on Toast Fresh String Beans Buttered Beets Cottage Cheese Salad Bishop's Bread
	Saturday, March 26	
Canned Grapefruit Farina Sausages Toast	Potato Pancakes Fresh Apple Sauce Bacon Curls Custard and Jello Parfait	Beef Loaf Potato Balls Buttered Wax Beans Chocolate Roll
	Sunday, March 27	
Sliced Oranges Wheatena Bacon Muffins	Broiled Tenderloin Steak Brabant Potatoes Braised Celery Waldorf Salad Strawberry Ice Cream	Eggs a la Goldenrod on Toast Steamed Rice Chopped Vegetable Salad Peach Whip
	Monday, March 28	
Prunes Puffed Rice Bacon Toast	Corned Beef Hash with Poached Egg Cole Slaw Cocoanut Custard	Fresh Ham Roast Mashed Potatoes Buttered Lima Beans Orange Chiffon Pie
	Tuesday, March 29	
Grapefruit Juice Corn Meal Doughnuts	Beef Stew with Vegetables Corn Relish Fresh Pineapple	Lamb Shoulder Baked Potatoes Creamed Asparagus Raspberry Sherbet
	Wednesday, March 30	
Stewed Apricots Oatmeal Bacon Toast	Escalloped Noodles with Tomatoes & Cheese Celery Hearts and Olives Norwegian Fruit Soup	Beef Patties Hashed Browned Potatoes Escalloped Cabbage Peach Melba
	Thursday, March 31	
Orange Juice Ralstons Fried Eggs Popovers Jelly	Shepherds Pie Chopped Carrot and Cabbage Salad Whipped Jello	Smoked Picnic Shoulder Rice Croquettes Buttered Peas Glazed Cherry Tarts

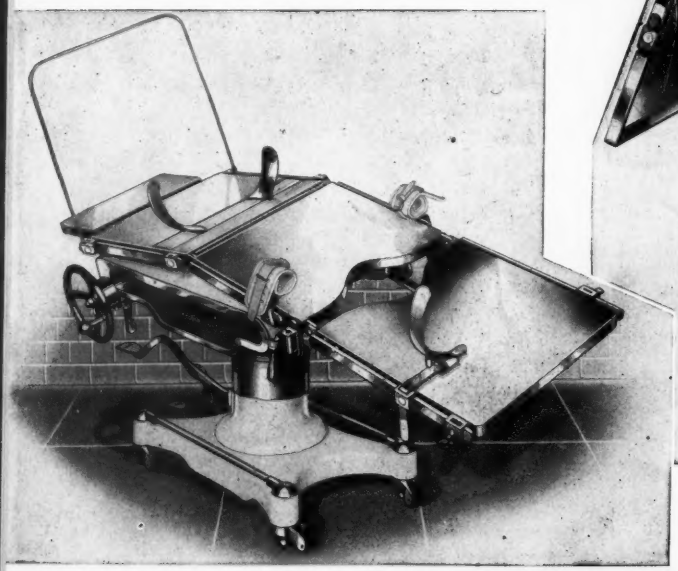
Department of Nursing Service

AMERICAN *Kny-Scheerer* SURGICAL OPERATING TABLES





Tiltometer



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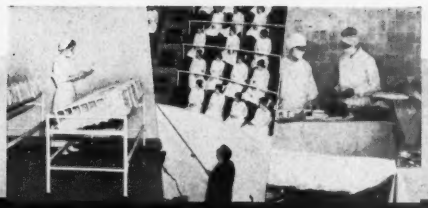


DEPARTMENT OF NURSING SERVICE

WINNIE ANNE COX, R. N.
Associate to the Director, Cook County School of Nursing, Chicago, Ill.
EDITORIAL DIRECTOR

THE ROLE OF THE INSTITUTIONAL NURSE IN THE TREATMENT OF OPHTHALMIA NEONATORUM

By BERNICE PERDZIAK, R. N.
Pediatric Department, Cook County School of Nursing

» » » THE NURSE plays a very important role to the individualist and to the community at large in the prevention of blindness. Through her efforts the institutional nurse renders possibly the greatest permanent service to the community and state, as economic estimates for the year of 1936 show that the financial cost of blindness in the United States was in excess of $40,000,000.* This appropriation, however, does not mitigate the personal suffering and deprivation that the blind individual must undergo, nor the inconvenience or handicap that those in contact with him must bear. Ophthalmia Neonatorum is listed among the specific diseases leading to blindness. Prophylactic measures have been extremely effective in the reduction of this disease, but stress must also be laid on prevention of blindness after the disease has gained a foothold.

Here we are not concerned with the prevention of infection, since that angle is taken care of by agencies and organizations through the education of the public and by State laws making Credé treatment compulsory, but more so with the nursing care after the patient enters the hospital.

*Harry Best, Social Work Year Book 1937.

Nurses who can adequately and competently give this specialized nursing service must have certain outstanding qualifications, and show an earnest and sincere interest in their work. It is essential that they are specially trained, and also that they show superior adaptability and a real conscience toward this type of nursing. Before the nurse comes to this department she has developed a nursing skill correlated with a sound theoretical knowledge of bacteriology and anatomy. The former gives her a good fundamental basis for isolation technic which is very necessary in nursing care of all communicable diseases. It makes her conscious of the need to protect herself, patients and other individuals from the infection. Second, she is impressed with the seriousness of all eye infections, since she learns that not only the gonococcus but many other organisms, namely, pneumococcus, Klebs-Loeffler bacillus, staphlococcus and bacillus coli, may cause ophthalmia neonatorum. The method of treatment remains the same except for a diphtheritic infection.

Figure 1

Figure 2

Figure 3

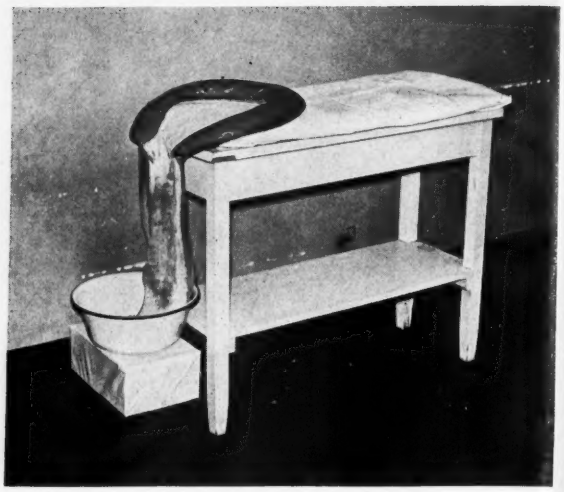


Figure 4

With the aid of an illustrated eye chart, a well qualified head nurse gives the new nurse a brief review of the anatomy of the eye to supplement and strengthen the knowledge she already has. This consists of a good description of the cornea and its transparent, delicate epithelial covering; also the conjuctiva which lines the lids and reflects itself over the eyeball. Emphasis is made on the extreme susceptibility of this membrane to infections, especially that caused by the gonococcus. The limbus of the eye is also of great importance as it is the area in which infiltration first begins, provided there is no abrasion on the cornea through which the organism may gain entrance. Another important factor to know is the purpose of tears which normally lubricate and wash the eyes free of any dirt or dust particles, and subsequently the location of the tear glands. In like manner medication may be instilled at this site so that it will reach all parts of the eye and conjunctival sac. In order to chart or report the condition of the eye, giving an accurate description as to location of infiltration, the nurse may liken the cornea to the face of a clock. The amount of discharge may be described as slight, moderate, or profuse, giving its color and consistency.

Let us now follow a baby with a typical gonorrheal eye infection. The mother or visiting nurse brings the baby into the admitting ward of the hospital where the baby is examined by resident doctor and intern. Smears of the discharge from the eyes are taken and examined microscopically. The baby, if brought in from the outside, will probably have had the infection for several days; seldom is he entered during the early stages. Both lids of both eyes (frequently unilateral) are very edematous with a profuse purulent greenish-yellow discharge. Figure 1 illustrates a typical acute gonorrheal conjunctivitis. As soon as a diagnosis is reached the eye department is notified, and preparations are made for the new patient. Upon his arrival on the ward the nurse dresses him in hospital clothes and irrigates his eyes with normal saline solution before the bath is given. Following the irrigation the doctor from the eye department examines the eyes carefully, opening them with the aid of small lid retractors. The observations of this initial examination are carefully recorded

Figure 6

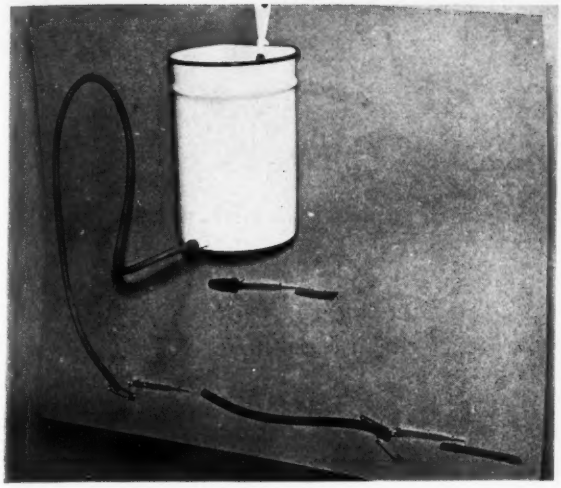


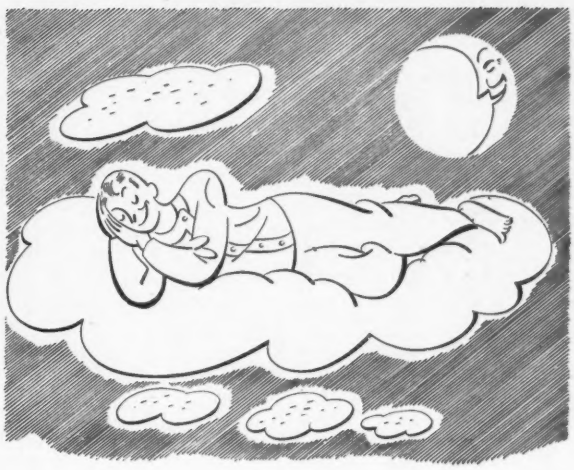
Figure 5

on the patient's record and the seriousness of the infection is discussed with the mother or visiting nurse before she is allowed to leave the hospital.

With a program which is continued through the twenty-four hours, this baby finds little time for rest or sleep. Thereafter the baby's eyes are irrigated every thirty minutes for about three weeks. Between irrigations he is fed, weighed, bathed, and treatments, such as sterile milk or blood are given intramuscularly (Figure 2). After about three weeks the acute infection usually subsides and the interval between irrigations is lengthened to forty-five minutes and gradually to one hour. The frequency of irrigations is decreased according to the amount of discharge and is also dependent upon laboratory findings. It is dangerous to stop irrigations too soon as recurrence is common when treatment is discontinued or intervals between irrigations too long. The average time necessary for a single treatment is from ten to fifteen minutes; however, one must remember that thoroughness is much more effective than the succeeding rapidity with which irrigations are done. The average baby stays in the hospital six weeks to two months. During the first three weeks he may receive as many as forty to forty-eight irrigations in twenty-four hours.

The baby is under the careful guidance of a pediatrician, as well as an ophthalmologist, as special precautions must be carried out to prevent severe upper respiratory infection or pneumonia. He also utilizes more energy than the average baby, due to constant handling; consequently a good dietary management is essential.

In the technic of the irrigation the chief aim is simplicity so that it may be clearly understood and readily adaptable under any circumstances. The nurse here learns to use adeptly both hands and nearly all her fingers simultaneously. She will become proficient and skillful whether she is lefthanded or right. The design of equipment is also simple; first, to facilitate cleanliness, and second, it is of the type that can be found in any hospital or home if necessary. The special table seen in Figure 3 may be improvised, as shown in Figure 4, by using a long sturdy table of suitable height over one end of which is draped a Kelly pad. This may drain into a bucket or wide basin placed on a box or stool. It should not be placed on the floor as there is too much danger of the contaminated



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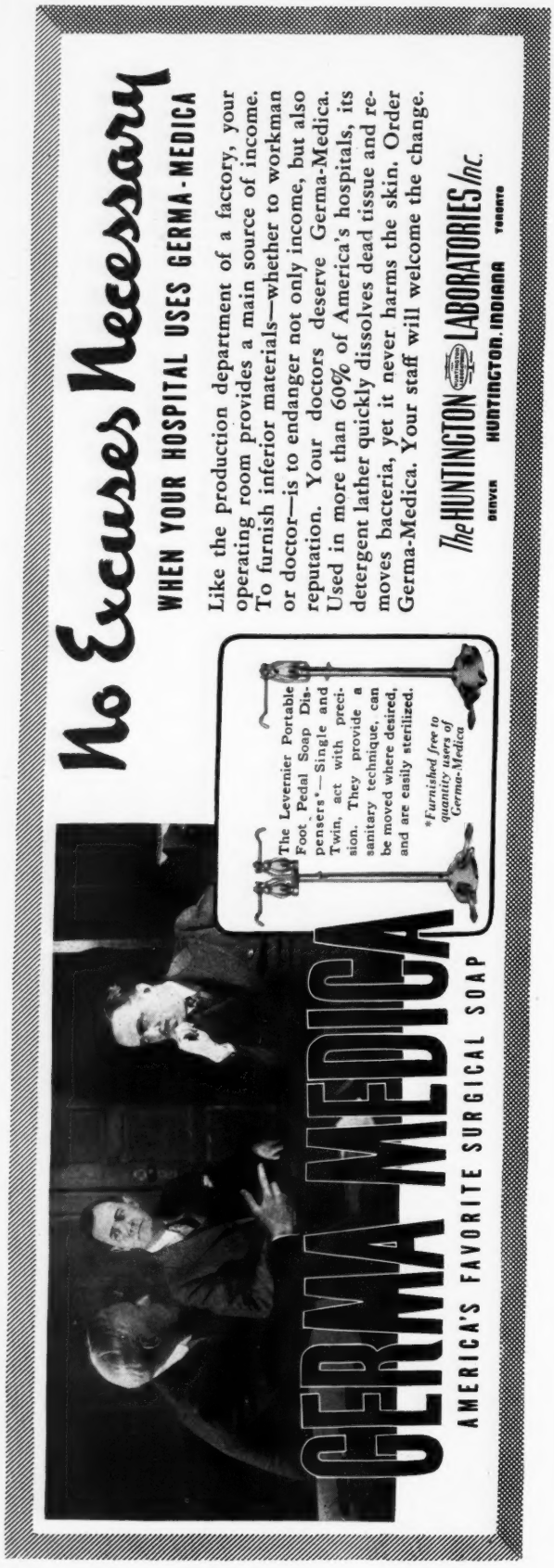
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solution splashing. The other equipment should be neatly and conveniently arranged so that it will not be necessary for the nurse to change her position after she commences the treatment. The rubber tip is planned to prevent force in the flow of solution. This is accomplished by the use of the glass portion of medicine droppers as connecting tips; the small apertures do not allow very much of the solution to flow through but give an even, steady stream. Lighting should be adequate, as irrigations must continue throughout the evening and night. In the home a floor lamp may be used, so adjusted that direct light will not shine in the nurse's eyes.

Equipment as seen in Figure 5 and method of eye irrigating technic are given below.

Purpose: To thoroughly cleanse the eyes in order to prevent blindness.

Equipment:

1. Irrigating table
   a. Suitable height
   b. Drain board (Monel metal top) attached for sewage disposal.
2. Light
3. Irrigating can equipped with rubber tubing and medicine dropper connection
4. Standard
5. Container with sodium chloride
6. Measuring glass
7. Three two-quart enamel pitchers
8. Container with sterile cotton balls
9. Sterile forceps
10. Small sterile towels
11. Container with sterilized rubber tips
12. Paper bag for waste
13. Container with sterile medicine glasses and droppers
14. Whisk broom
15. Container with green soap for contaminated tips
16. Rubber bib
17. Goggles
18. Nurse's gown

Precautions:

1. To the patient (as described in the process of procedure below)
2. To the nurse
   a. Use isolation technic
      1. Wear a gown
      2. Wash hands as designated in procedure
   b. Wear goggles (same as in Figure 6)
   c. Hair pinned back
   d. Avoid bringing hands to face or rubbing eyes

Procedure:

1. Hang irrigating can on standard which has been placed about one foot away from the drain board. A height of six inches above the table is sufficient to obtain a good flow without having a dangerous force of solution through the tube.
2. With sterile forceps remove one sterile connecting tip and attach to connection on irrigating can (a safety pin may be used to hold it together firmly), and hang on clean hook on irrigating table.
3. Place ten small cotton balls on sterile towel at head of table.
4. Place small towel on drain board for baby's head to rest on.

(Continued on page 58)

U. S. Birth Statistics (8 year average)	
Total births per year	2,156,762
Sets of Twins per year	24,505
Sets of Triplets per year	242
Sets of Quads per year	**4**

The KASPER QUADS were born at St. Mary's Hospital in Passaic, N. J., on May 9th, 1936. They were premature, 7 months babies, and were kept in incubators the first 8 weeks of their lives. Their average weight at birth was 3 lbs., 5 oz. When they left the hospital 9 months later, their average weight was 17 lbs., 11 oz. and at age of 1 year, 7 months, it was 23 lbs., 13 oz.

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MEDICAL RECORDS DEPARTMENT

EDNA K. HUFFMAN

Director, Training School for Medical Record Librarians, Grant Hospital, Chicago

EDITOR

THE ROLL OF THE RECORD LIBRARIAN IN MEDICAL RESEARCH

By HELEN A. HAYES, R. R. L.

St. Alexis Hospital, Cleveland, Ohio

» » » THE VALUE OF the scientific medical record from the standpoint of clinical research depends to a great extent upon the accuracy and completeness of the information contained, and also on the availability of the record for purposes of study. The record librarian is working upon these two requisites daily, and is preparing by her very thoroughness for future study of these clinical records. It is only when she has developed to a very marked degree her power of observation and a scientific attitude toward her work that she can give to her hospital the valuable contribution to research that it is possible for one well trained and fitted for this work to give.

Clinical records should be comprehensive and complete in all details, to be of any value whatsoever for medical research. You have, I am sure, all had the experience of watching the analysis of several hundred records being made in your own hospital for some particular clinical study, and have observed that because of the lack of complete information a great many were discarded as useless. The record librarian in her work is dealing with scientific documents, and as such it is up to her to see that the material has all the qualities of such a document. Omission and the lack of information makes a record almost entirely useless for study and detailed analysis. It may be quite impossible for the librarian to accomplish all she would like to, but with the help of a good record committee working with her, she can accomplish much.

It is not necessary to go into detailed discussion of what constitutes the component parts of the complete record. One suggestion, however, may not be entirely amiss at this point, and that is the inestimable value of certain special record sheets when they can be used to advantage in clinical records. I refer here to such special forms as tumor or cancer records, fracture records, consultation records and other special forms. These prove of great value in research work on any given series of cases. They are extra sheets to be added to the charts, and do not take the place of any part of your regular chart. They make for the simple evaluation of the record when it comes to clinical research at some later date, and the statistics thus obtained from such a series is more accurate. These forms, if not already in use in your hospital, can be brought to the attention of your record committee, and if accepted for use will prove of great value for future research, making possible the assembling of a large volume of material for statistical purposes.

Every approved hospital is really a center of scientific research in itself, and there should be constantly emanating from the hospital scientific clinical papers which have been prepared largely from the clinical records of patients treated there. It is for this reason that the record librarian's part in the hospital's research work is a very important one. As medical records are the source of nearly all information for research, it follows that upon the calibre of the record librarian's work depends largely the contribution the hospital's clinical records will make to the research work of that hospital. The librarian must always be ready and willing to aid the staff doctors in securing suitable case records for their various papers and studies of cases. The records must be available, and the accuracy with which the librarian has compiled, indexed and cross-indexed the diagnoses and complications, makes possible an accessible series of cases on any given study. Given accurate records to begin with, and the proper classification of those diseases, there is always available in the hospital a wealth of valuable medical knowledge for accurate scientific research, to which the record librarian really holds the keys.

It is entirely up to the individual record librarian just how much she can contribute to the medical research being done in her hospital. She must be extremely proficient, and have developed, during her years of training and experience in her profession, a scientific viewpoint and interest in regard to her work. If this interest in the progress of scientific medicine is lacking her work will soon

Presented before the Ohio State Association of Medical Records Librarians, Columbus, Ohio, April 14, 1937.

disclose this fact. In the compilation of the clinical records of the hospital she should keep before her always the viewpoint of their future contribution to research work. She has learned how to evaluate the medical data contained in these records, and it is her duty to have these records as complete as possible before she has filed them away, so that when they are again brought out for research purposes, they will stand as something definitely to her credit.

As to the actual help the librarian can offer to the staff of the hospital in its research work, much depends upon how available and complete the records are for any particular study. Every record containing the diagnosis under study should be available from the disease or operation index, for it is often from the very incidence and recurrence of combinations of diagnoses that may come some valuable contribution to scientific research from your hospital—perhaps some great discovery that will prove of great value to science. With the medical library of the hospital correlated with the record department, the record librarian is able to furnish both the case records and the comparable data from the current literature on any selected study, compile bibliographies, and generally prove herself to be an important factor in every review of interesting cases, or series of cases, being made by the staff.

In conclusion, I personally feel that the fascination of the medical record librarian's work lies in assuming to the fullest extent all the responsibilities which rest with her profession for continually striving toward higher standards in medical records.

Obstetrical Records for Research

By H. F. BECKMAN, M.D.
Professor of Obstetrics, Indiana University School of Medicine

» » The object of all work pertaining to medical records is the advancement of medical science for the benefit of humanity, and experience is the teacher of wisdom. Thus it is that the value of medical records is increasing daily, and while you must think of them collectively, giving each group equal importance, the doctor thinks of only one group at a time, and I think primarily of the obstetric records.

In obstetrics, because of the sentimental interest which every human feels toward an infant, or the mother of an infant, and because of the importance of the birth rate in maintaining the population of any community, we have centered upon our records the scrutiny of the doctors, the public, the press, the social welfare workers and patrons, which may partly explain why our records are usually quite complete. Superficial examination would leave the impression that they likewise are quite uniform and specific, and yet obstetricians feel that just these last qualities are our weakness. We are not yet sufficiently specific in what we say.

For instance, we will content ourselves with the expression "toxemia of pregnancy" when we should specify whether of early or late pregnancy, whether primary and acute, or whether same is engrafted upon a pre-existing nephritis, essential hypertension, chronic infection, lues, thyrotoxicosis, or some other undefined state. And so it is with placenta previa, with pelvic deformity, with anomalities of the powers, whether this be due to position

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of child or some developmental anomaly of the uterus. The cause of post-partum hemorrhage is seldom stated, and yet should be known. Retained or adherent placenta is not the same thing, and adherent placenta is caused by various conditions, and the one present in a given case should be stated.

As it is with complications, so it is with morbidity. In most records, temperature alone is the standard by which morbidity is measured, and by this measure of temperature, there are twelve different methods of expressing morbidity used by as many leading hospitals. A patient with unrepaired injuries need not show any elevation of temperature, and yet her condition would certainly require mention in the morbidity group. Thus we know that childbearing is followed by permanent morbidity of 10 per cent which does not find expression in general statistics.

All of this calls for uniform standardization and the attempt to this end finds its expression in the different systems advanced and used in different hospitals. It is unfortunate that none of the great organizations in medicine has had the courage to adopt and recommend one of the various existing systems of nomenclature for the use of all. It is true that none meets all requirements, and that none is complete. But there will always be a changing conception of disease and hence changes will always be necessary. It would be easier, however, to keep abreast with one system than with several systems, and this should be the aim of all interested in medical records.

While we, as physicians, decry the existence of numerous confusing systems, since it does not permit us to compare results and establish statistics for the purpose of deciding best methods for treatment of complications, the medical records librarian feels this deficiency in a more personal way, since statistics do not provide the information which is requested upon certain occasions.

After uniformity of nomenclature is accomplished, which it will be some day, comes the personal equation of the physician recording the history or results and his interpretation. Some men just can't lose, hence never have any failures. The personality and temperament of a doctor is reflected in his medical records just the same as is his medical ability, and librarians know these qualities of individuals better than other physicians do. All who are interested in hospital practice and services will soon be out of patience with the man who does not realize and accept his obligation along the line of records. Not only are the doctors responsible for clinical records, but it is an obligation that they owe to hospitals, since the records constitute one of the main criteria upon which staff members are rated, and loyalty demands of each man that he do his part in this direction or move to another climate.

We are indebted to our colleagues, and more especially to the younger generation since we are establishing medical history by which they will be guided in their attempt to carry on. We are obligated to ourselves in this matter, since memory fails us and it is the written word that will perpetuate our activities and establish who and what we are in medical practice. We are obligated to the patient since our observations and treatment may mean life or death to him in some future manifestation. All of above is recognized in the medical teaching institutions, and history-taking and keeping of records is receiving more attention.

The aim of all should be:

1. More complete analysis of the various groups of disease.
2. Uniform standards of nomenclature.
3. Enthusing the on-coming generation in the value of records.
4. Devoting ourselves to the records of our individual patients.
5. To the librarians, continue in your efforts, in your patience, in your graciousness, in your loveliness and some day, Utopia will come.

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Appraisal of Physician's Work . . .

(Continued from page 15)

the best interest of the patient; but here again care must be exercised. The members of the governing body, being laymen, are not qualified to interpret the information contained in the records of the work of individual physicians, so must delegate that duty to the medical staff and be guided by the advice received from that source. The medical staff in its turn should appoint a small committee to study these records, delegating to this committee the authority to study confidentially the work of individuals. Having performed this duty the committee, which is qualified to exercise judgment, should make recommendations for appointment to staff positions, omitting any of the confidential details which has been made available to them. Should any individual wish to appeal against the judgment of the committee, he has the right to submit his own record in support of his appeal, but otherwise the medical staff should make its nominations in conformity with the recommendations of the committee.

In effect, the record of the work of the individual physician gives a reasonably accurate basis on which to judge competence and competent physicians are strongly in favor of such judgment since it proves their professional standing. The chief obstacle which prevents its adoption universally is that the members of the staff have not realized its importance to the extent that they are willing to undertake the slight amount of extra work involved. Without some such record, however, the governing body cannot effectively perform its duty. It must continue to make appointments to the medical staff on the haphazard basis of reputation and unsupported opinion.

ANESTHESIA, PATHOLOGY, X-RAY

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CONTRIBUTING EDITORS

ETHER

By BEN MORGAN, M. D.
Chief Anesthetist, Grant Hospital, Chicago

» » » ETHER is being used as the major part of most anesthetics and while it is slightly on the decline at the present time, it has held a lead over all other anesthetic agents for a period of some seventy years after it was first introduced.

The anesthetic ether is an ethylic ether or sulphuric ether, having a formula $(C_2 H_5)_2O$. It is a colorless fluid with characteristic odor and as odors go, very high in its efficiency to penetrate the olfactory nerve ends. To use a volatile oil with the object of deceiving its odor, one must use something like oil of cloves which is one of the most highly penetrating odors among the essential oils. Bitter orange is fair and sweet orange has but little value.

The specific gravity of ether is less than alcohol and varies somewhat in different countries. In England, the specific gravity is .720 to .723 while in the United States the specific gravity is a little less—.713. However, different manufacturers, at one time, produced ether with a different specific gravity or ability to evaporate. This ability to evaporate caused many discussions, but actually the response of a patient to an ether anesthetic depends more on the manner in which it is given than it does on the label of the individual manufacturer or the varying differences in volatilicity.

Recently Di-vinyl ether has been put on the market and is at least creating its share of attention.

Bearing in mind that ether is the standard to which all anesthetics must be checked does not preclude certain objectionable features. The induction by ether is prolonged. We choose to shorten this induction time. Ether further produces respiratory irritation and salivation. Because of some of these properties there has been a ceaseless search for their correction and great expense and energy has been expended. Some improvements have been made—for instance, a patient is now given a gas induction followed by ether in order to avoid the prolonged mental phase, the gas causing unconsciousness within a few seconds as well as partly anesthetizing the respiratory tract which lessens the ether irritation. Aside from the use of gas in the attempt to side-step the irritation by the drop method, many other things have been used—such as Chloroform, A. C. E. mixture, Ethyl Chloride, Ethyl Bromide, Somnoform, Bonoform, and Di-vinyl ether.

There was, at one time, a highly volatile ether known as "Cotton-process." The "Cotton-process" ether was advertised on the basis that the real bulk of the ether was not the element that caused anesthesia but it was a certain by-product that was held within or around the ether molecules, that by extracting this element from around the ether molecule by the so-called "Cotton-process," it produced a liquid a little too volatile for the drop-method but quite satisfactory as an anesthetic agent.

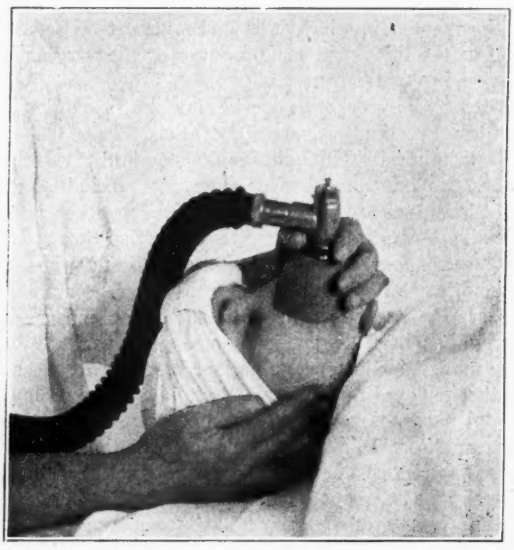
The impurities of ether have come to light in the last eight or ten years. Our experience has been that instead of ether deteriorating and becoming unfit for use, it vaporizes after the seal is once broken and is lost. However, ether is deteriorated by light. We, therefore, advise that all ether containers should be metal jars rather than glass ones. If the metal jars are not available, we would suggest a metal cover or a dark cloth covering over the glass ether bottles to prevent light exposure. Ethyl sulphide, ether peroxide, and acetal-dehyde are the likely substances found in ether that has been stored in clear glass containers. Metal containers are used throughout the United States for the distribution of ether. Therefore, exposure of ether to light occurs after it has been removed from the original containers and put into apparatuses that are equipped with clear glass containers. Some apparatuses do not use glass at all in the construction of their equipment.

It is necessary to compare one anesthetic agent to another and chronologically ether must be compared to chloroform, although chloroform is quite out of date in so far as general usage is concerned. Some husky subjects handled properly, show but little evidence of irritation of the cerebrum when taking an ether anesthetic and almost no one struggles with chloroform. The respiratory stimulation with ether is quite pronounced, producing long, deep, rapid respiration, while chloroform causes a slight increase in breathing only to reach a slow shallow rhythm almost too gentle for comfort. Although the

principle of rebreathing to stimulate the slow respiration in chloroform might, on the face of it, seem practical, this is overshadowed by the possibility of over-concentration of chloroform vapor, causing great danger. When rebreathing is added to ether without proper instruction and control, it may cause a deep, puffy, blowy respiration not desirable for abdominal work. The difference between the normal breathing stimulation of ether and the stimulation seen in the closed method is the excess of carbon dioxid in the rebreathing. This excess, therefore, should be removed in a well conducted ether anesthetic. The working margin or plane in ether between the loss of spinal reflexes and the paralysis of the respiratory center is a very wide plane as compared to chloroform. This plane has a proportion of about 1 to 10. In other words, when a patient is just under anesthesia, he would withstand ten times deeper ether anesthesia than chloroform. Another way of putting it—his entire body cells could be saturated almost to the point of destruction while the vital reflex mechanism would still sustain life. While this is a great quality in the safety of ether, it is also the excuse for having so many poorly trained anesthetists.

To maintain ether anesthesia in an average adult, it requires 16 to 18 per cent of ether in the inspired air. It so happens that an ordinary mask that is four inches in diameter and three inches high covered by twelve layers of gauze or one layer of stockinette must be kept quite moist with ether in order to maintain anesthesia. These ether masks have become quite uniform and are actually a little small in size, which puts a burden on the anasthetist when anesthetizing an average adult but is quite adequate for small patients. With a small mask only a limited amount of ether will vaporize so that it is not easy to overdose a patient with ether vapor when the usual Ochsner mask is used. Skill is really necessary to overdose a patient. An unusual mask like the Ellis inhaler could be used or a mask may be constructed out of a newspaper folded like a sleeve, about four inches in diameter, with gauze stuffed part way down and ether poured in. This might cause the accumulation of a high enough concentration of ether vapor to do damage. Ordinarily an extra towel or lap sponge is wrapped around and over the mask when deep anesthesia is required. By making a covering over the mask thicker and wrapping a towel around the patient's face to include the lower margin of the mask, a higher concentration of ether is obtained. This thicker covering also causes the patient to rebreathe a little more carbon dioxid and tends to prevent shallow breathing.

The history of ether masks dates back some seventy years. Contrivances of many forms have been developed quite independently of each other. In the early 70's and 80's, it was thought that ether could only be given from some sort of funnel shaped mask with high walls or from an inhaler like the Hewitt type which had, in addition to an ether gauze chamber, a rubber bag in which to rebreathe. In 1846, at the first clinical demonstration of the giving of ether, it is interesting to note that use was made of a round glass bowl eight inches in diameter containing a large sponge on which the ether was poured for vaporization. This was connected to a mouth bite by large airway on the side of which was a large air-vent. When the air-vent was wide open, the patient would not breathe through the "fish bowl." As the air-vent was gradually closed off, the additional strength of ether was secured by virtue of the patient having an increased air intake through the "fish bowl" containing the ether sponge. However, when ether was administered in the early days, the anesthesia was usually accompanied by a violent performance on the part of the patient. Operations were too frequently submitted to as a last resort, the patient being well aware that it was a serious condition if he had to take an anesthesia. Much of the minor surgery was done without anesthesia and, of course, with the accompanying pain. The writer has often sat in clinics during his student days and waited for the performance of ether induction. The patient was strapped or held securely to a table. No attempt was made to lessen the mental anxiety and with the cautious slow administration of the drop method, the patient went through a transitional state very similar to that seen in the imbibation of liquor, finally leading to complete paralysis. Of course ether carries the patient through the exhilarated, excited phase and into the paralytic stage much faster.



The old and the new method of administering ether.

Those patients were inclined to talk, often put on an elaborate exposé. It was not uncommon to hear the wildest of mental elaborations and occasionally things were said that would even make the most worldly blush; or bits of information which would be detrimental if brought to light in a law suit were shouted. It was necessary, therefore, for the courts to rule upon statements made by a patient undergoing anesthesia because in most instances it was a sub-conscious babble without any tangible basis. Fortunately, these episodes are not remembered by the patient following his recovery. The courts further ruled that statements made by patients under the influence of anesthesia would not be accepted in any law suit, that the patient is not responsible for his acts after the first element of the anesthetic had been adminstered. This, in turn, puts the burden on the anesthetist who should try to administer the anesthesia quickly enough so that the patient cannot talk or injure himself or others should he struggle during the administration of an anesthetic.

As the progress of science travelled upward, anesthesia was in no way lagging. Better understanding of agents used and method of administration have altered the picture almost entirely. Patients now do not go to a hospital to die—they go to a hospital to get well and the operating room has become known as a place where diseased tissue is removed from the healthy. The usual scene in the operating room today is the schedule of the operation with the doctor's name, the assistant's name and the time. The patient has been in the hospital over night and has been given sedatives to dull the mental activity. He is placed on a suitable carriage and transported to the operating room, almost in a normal sleep without care or apprehension of the surroundings. Conversation, the handling of instruments and unnecessary noises cease, the anesthetic is started almost immediately and the patient, if he arouses, is assured of good attendants and ultimate success of his operation. The anesthetic is timed so that full anesthesia required for the given operation is reached within a minute of the time that the attendants have thoroughly dressed themselves in sterile attire. The instrument table, previously arranged with the sterile supplies, is swung into position and the operation begins at once. The ether is dropped or carbureted through an apparatus with known dosages, maintaining the level of anesthesia much on the same carburetor principle that furnishes the power for the gliding automobile. After the operation on the deeper and more sensitive structures is completed, the carburetor mixture is lessened while the deeper layers of the tissues are sutured. By the time the skin is closed, the anesthetic agent has been so entirely ventilated from the patient that there may be subconscious movements although he is still entirely free from pain. Neat dressings are applied, secured by proper bandages, and the patient replaced on the carriage and escorted by two trained attendants back to his room. Often he awakens from his premedication in amazement that the operation is already over. Rarely do we have the memory lingering with the patient of unpleasant or painful experience.

New Hospital for Norton, Kans.

» » A new 240-bed hospital is being planned for Norton, Kansas. The building, to be five stories high, will cost $367,000, a portion of which will be borne by the WPA.

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CONTRIBUTING EDITORS

STAINS ENCOUNTERED IN THE HOSPITAL LAUNDRY

By L. T. HOWELLS
Chief Chemist, The Cowles Detergent Co., Cleveland, Ohio

» » » UNFORTUNATELY the users of medicinals are not always able to avoid staining linen when handling pharmaceutical preparations. The hospital laundry, therefore, presents a special problem in stain removal because of the large number and varied types of medicinal stains not encountered in the commercial power laundry. To this end, we have made a study of the most troublesome stains occurring on hospital linens and we find that many of them can be dealt with effectively, in minimum time, and without serious injury to the fabric. So far the results of this investigation have revealed specific treatment for the following stains.

Acriflavin

This stain is an orange-yellow dye commonly used in medicine and therefore frequently found in hospital work. It is very resistant and requires three separate successive treatments for removal. First the articles should be given a soap and water wash. Secondly, treated with acetic-alcohol (1:9) and finally given a permanganate-hydrosulphite treatment.

The permanganate-hydrosulphite treatment consists of treating the goods with a solution of potassium permanganate (2 oz. per gallon). Follow by thorough rinsing and remove the remaining brown coloration by treating with a solution of sodium-hydrosulphite (2 oz. per gallon).

Argyrol - Silver Antiseptic

These stains are not removable in the ordinary washing process, but must be treated locally.

The most efficient silver stain remover consists of a solution of bichloride of mercury and ammonium chloride. In making up the reagent dissolve 5 grams of bichloride of mercury and 5 grams of ammonium chloride in 100 cc. of water. Immerse the stained part of the fabric in the *hot* solution and follow with thorough rinsing.

Iodine (tincture) is also recommended for the removal of silver stains. Apply iodine solution to the stains with a glass rod, forming silver iodide. Allow to remain about two minutes, then remove excess iodine with soduim thiosulphate followed by thorough washing.

Balsam of Peru

Balsam of Peru compounds give a brown stain which respond to acetone, xylol, chloroform and alcohol.

Benzoin Tincture

The brown stain from tincture of benzoin is most readily removed by alcohol.

Gentian Violet

Treat the stained articles by soaking in alcohol-acetic mixture (9:1) for five minutes. Remove and rinse; follow with light bleach. Old stains may leave yellow residue. In this case repeat above treatment for complete removal.

Ichthyol (Black or Gray)

This compound is composed chiefly of ammonium sulphonate. When fresh the stains are removed in the regular wash.

For old hardened stains a pre-softening by dipping in cresol solution is effective before the recommended soap.

Conducted in cooperation with The National Executive Housekeepers Association, Inc.

Iodine

When iodine is dropped on unstarched material, it makes a brown or yellow stain, but on starched material a deep blue or black. For removal, spot with five per cent solution of sodium thiosulphate (hypo).

Mercurochrome

Mercurochrome is dibrom - oxymercuri - fluorescein, which generally appears upon the market in water solution of 20 to 1000, although higher concentrations up to fifty per cent are in use. The red dye stain can be removed from cotton through oxidation. When the stain is fresh, bleach will usually bring about removal. When old and set, it is more resistant and the following method is recommended.

Work the stained articles in a two per cent solution of potassium permanganate at 100° to 130° F. for five minutes; rinse and then work in a two per cent solution of oxalic acid at 120° to 130° F. until all brown coloration is gone; rinse thoroughly.

This treatment will remove all ordinary mercurochrome stains and can be repeated in special cases where found necessary.

Mercurochrome stain on animal fibres is subject to reactions which make it permanent. Substantial lightening of stain, if not complete removal, can be obtained by the use of acidified alcohol (50:50 alcohol and acetic). For cleaning up stains on hospital equipment a mixture of ninety per cent alcohol and ten per cent sulphuric acid is generally employed, but this, of course, cannot be used on fabrics.

Merthiolate

Merthiolate stains are the source of much grief in the laundry, especially in hospital plants. The following information on their removal will be found useful wherever their presence mars quality.

Merthiolate is the sodium salt of ethyl mercurithiosalicylic acid, containing about 49 per cent mercury in organic combination. It generally appears upon the market in solution of 1 to 1000 as Tincture Merthiolate. Stains from this agent, which are pink in color, can be completely removed from vegetable fibres by immersing in a boiling two per cent solution of a completely controlled alkali. For spotting work and stains on animal fibres, an acidified solution of alcohol is effective. The acidified alcohol solution can be made by adding approximately 5 cc. of half normal hydrochloric acid to 100 cc. of alcohol, or using a mixture of 50:50 alcohol and acetic acid.

Methylene Blue

Methylene blue is a basic dyestuff used in commercial and pharmaceutical preparations. Alcohol is usually effective on fresh stains. Pyridine-sulphite treatment is recommended for old stains. This treatment consists of five per cent solutions of *hot* pyridine and sodium hydrosulphite. Alternate from one solution to the other until stains in question are removed.

Picric Acid

Picric acid dyes cotton a permanent yellow and produces stains which are exceptionally fast to washing. For removal, immerse the dry stained fabric in a 50:50 mixture of alcohol and ammonia water (regular household five per cent.)

Ointment

Ointment is often water repellent, which accounts for the difficulty in removing the stains in the ordinary washing process. To overcome this it is necessary to remove the greasy material with a grease solvent such as gasoline, ether, carbon tetrachloride, etc., and then follow with the recommended treatment for the residual stain.

Prontosil

This stain is a bright red dye commonly used in medicine. It is generally removed in the regular laundry process. If a slight residual stain persists it can be entirely cleared up with a light hypochlorite bleach.

Scarlet Red

This stain is a bright red dye commonly used in medicine and therefore frequently found on hospital work. The stain is removed or considerably reduced in the regular wash. It readily responds to acetone which is a solvent for this particular dye.

Silver Stains

Silver stains which appear as brown or black stains do not respond to washing or the common stain removers. The stains usually develop from colorless silver salts, such as silver nitrate, which are not noticed until the damage is done. If hospitals and other users of silver solutions insisted on ammonia treatment of articles spotted with $AgNO_3$ immediately after contamination, the laundry owners would be saved a great deal of grief, because the stains would then be subject to removal in the regular wash.

For the removal of silver stains the bichloride of mercury and ammonium chloride treatment, which is described under Argyrol, is highly recommended.

Pemphigus Neonatorum . . .

(Continued from page 26)

8. Mothers were instructed to keep the baby wrapped in its blanket on top of her covers.

9. No visitor or husband was allowed in the room during the nursing period.

10. The isolation of one baby from another in the nursery with its own bath blanket, thermometer, etc., was required.

11. Babies were kept dry, diapers changed frequently, and linen changed after any regurgitation.

12. During the warm months the babies were kept cool by regulating the room temperature and the amount of clothing as much as possible.

13. All babies were taken from the nursery who had a rash, discharge from eye, furuncle, folliculitis, or a lesion suggestive of pemphigus. These babies were taken care of by an entirely different personnel, nurses, interns, etc.

14. All blebs were opened immediately under 95 per cent alcohol and a small amount of ammoniated mercury applied. Contacts were given a potassium permanganate sponge bath.

Since that time other ideas have been added:

1. Interns and nurses are instructed to wash their hands in lysol solution and rinse them with sterile water before handling the baby immediately after its delivery.

2. The skin of the baby must not be wiped with gauze or towel in the delivery room. The cord is tied, the eyes Credé and the baby placed in sterile blanket and taken to the nursery.

3. A good light antiseptic oil is used for the baby's skin. Certain brands of oil are irritating and the babies develop red, blotchy skins.

4. All personnel entering the nursery wear cap, mask and gown.

5. The careful washing and auto-claving and handling of linen with its transportation to the nursery is being stressed.

6. The simpler procedure of leaving the layer of vernix caseosa on the skin of newborn is being followed at the present time and seems to be effective in the prevention of skin irritation.

The responsibility for the prevention of pemphigus rests with (1) the obstetrician in the handling of the baby in the delivery room, (2) the pediatrician, (3) the nurse in following strict technique, (4) the mother in handling and feeding the baby, (5) the help in caring for the linen and in cleaning the nursery.

The control of pemphigus rests (1) in prevention, (2) in control of epidemics, (3) in treatment of cases. The most important of these is the prevention of the occasional case, for by controlling the single case the epidemic is prevented.

Sea-Going Hospital . . .

(Continued from page 25)

service is so great that one day,—"believe it or not,"—a wounded seal flopped up on the gangway. She was taken aboard and her lacerations carefully sutured. I am informed that she returned daily at 0845 for dressings until the wounds were healed. After an absence of a month or more, she returned one morning, proudly displaying a baby seal, but that was after I had left the ship.

Many uninformed persons confuse the Relief with relief, some even calling it the relief-ship. The mother-in-law of one of our doctors was asked where her daugher's husband was on duty.

"On the Relief," she replied.

"On relief?" came the raised-eyebrows query. "Why I thought naval officers were quite well paid."

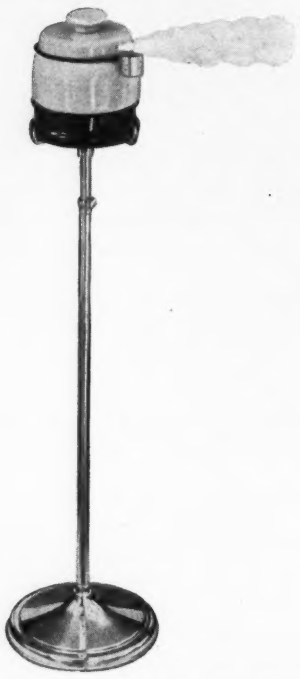
New Hospital Building for Dallas, Tex.

» » Civic leaders, dignitaries of the Catholic Church and physicians recently paid tribute to the order of St. Vincent de Paul and especially to one member, Sister Brendan, as dedication ceremonies were held for the $125,000 free clinic and children's hospital of St. Paul's Hospital.

Opening the ceremonies, Bishop Joseph P. Lynch administered the benediction of the sacrament in a service at an altar on the fifth floor of the building. Following the ceremony, a program of addresses began in the clinic auditorium and social center in the basement.

NEW EQUIPMENT

Kenwood Electric Steam Kettle



» » The Kenwood electric steam kettle, illustrated above, has recently been developed by Will Ross, Inc. of Milwaukee. It is a compact, easily portable vaporizing unit with which a controlled stream of steam may be directed at the patient. Its height is adjustable so that it can be used while the patient is lying down or sitting up. To operate you merely fill the kettle with water and plug into any 110 A.C. outlet. A medicant cup on the outside of the kettle permits using medicant when desired, without gumming up the heating element or interior of the kettle. The kettle is ivory porcelain enamel with a black trim. The stand and heavily weighted base are chrome plated. The vaporizer operates 1½ to 2 hours on one filling.

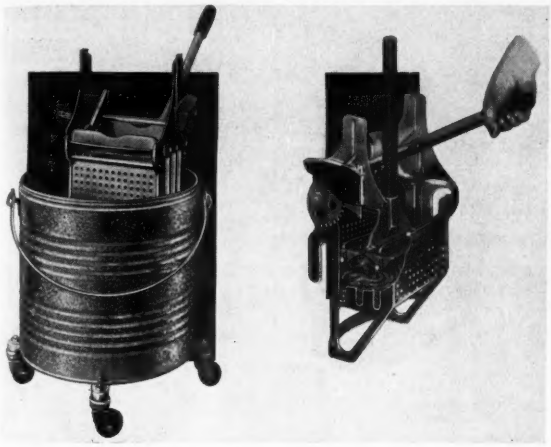
Mop-Wringer

» » A new mop-wringer has been announced by Geerpres Wringer, Inc., Muskegon, Mich. It is designed to squeeze rather than wring mops, and in addition to being remarkably efficient is said to result in virtually doubling life of mops.

There are no parts subject to any material wear in this wringer. In operation, the mop is inserted in the mop receptacle, a handle is pulled down and then released, and the dry mop is removed.

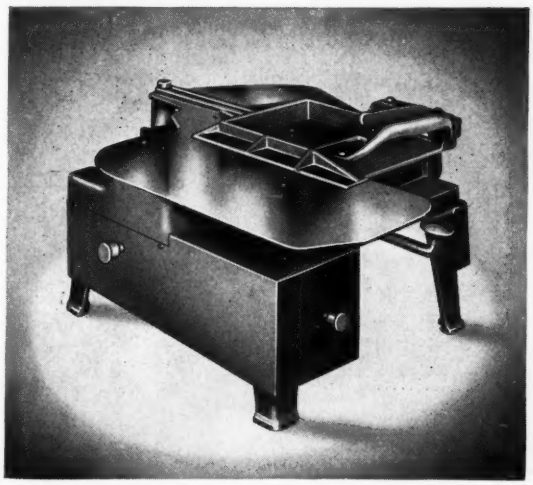
As the handle is pulled down, two plates fold down from the top of the mop container to seal the mop into the container itself. As the movement of the handle is continued, those plates—through a sector gear and rack operation—are moved down into the perforated mop receptacle, squeezing the mop dry. With this mechanism, uniform pressure is available at all times, regardless of the size of the mop used.

The squeezing action is downward, into the pail, preventing spattering. Straight side pails or tanks, either round or square, may be used. Splash is eliminated, keeping workers' feet dry. All metal parts are processed for rust resistance by plating. Rubber grips are provided on the handle to prevent marring of walls.



Available with the wringer, if desired, is a special round tank mounted on high grade ball bearing casters, with the bearings sealed against moisture. These containers are hot-dip galvanized and are ribbed for strength.

Small Model Ice Cube Cutter



» » Hospital superintendents who have seen the newest Reinhold ice cube cutter (Midget), a small floor or table model, embodying all the mechanical efficiencies of the larger models, say that the manufacturers have produced something that will meet a long-felt want.

A 7¼ by 7¼-inch ice cake can be accommodated in the Midget Reinhold. This cake is turned by means of a lifting plate. Cubes are 1⅜ inches in size.

An efficient, simplified V-belt driving mechanism has been devised for the new Midget ice cube cutter, with no gears used. The motor is drip proof.

All Reinhold machines may now be purchased through an institutional supply jobber.

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And with these stills you are always sure of a never-failing supply of pure, troubleproof water. For these stills are completely automatic. You simply start them—from there on your safe-water supply is assured.

Made of copper and brass throughout, Barnstead Single, Double and Triple Stills last for years. Linings are of pure block tin. Each still has counter-current operation, condenser venting, preheating, and baffling. Very compact, these stills —including distilled water storage tanks—are easy to install. Sizes run from ½ gallon per hour up. Operation by gas, steam, electricity or kerosene.

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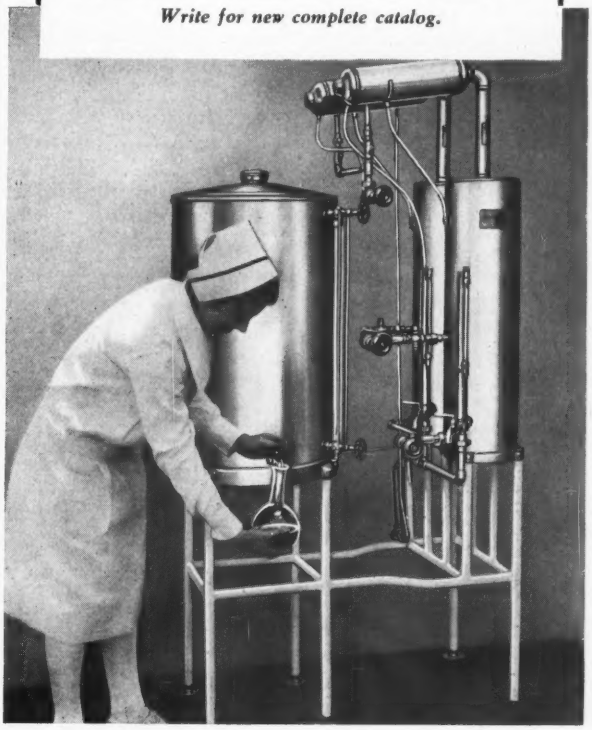

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STILL & STERILIZER CO. Inc.

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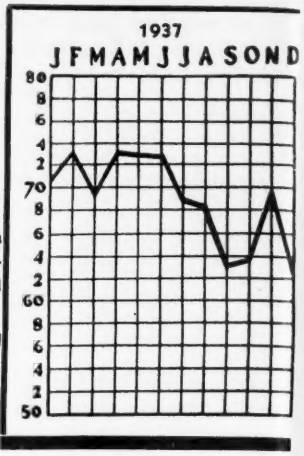
How's Business?

The charts and figures on this page are based on returns from 91 community type hospitals in 35 states. "Hospital Management" was the originator of this business chart of the hospital field. Watch it every month.



Total Daily Average Patient Census

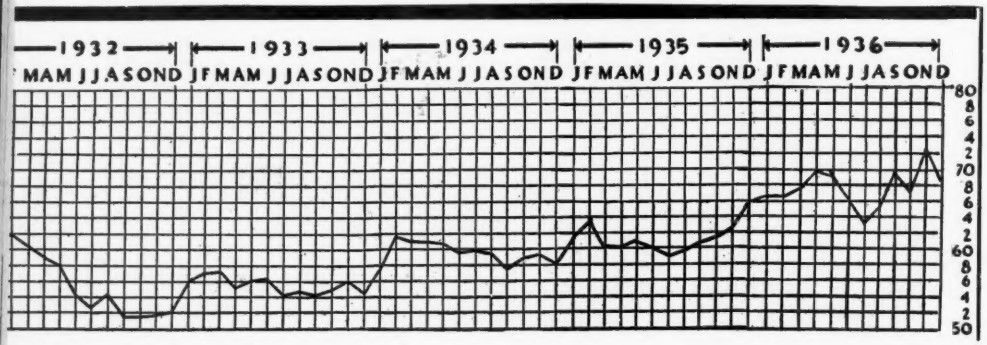
*September, 1932	9,125
*October, 1932	9,226
*November, 1932	9,328
December, 1932	9,403
January, 1933	10,037
February, 1933	10,197
March, 1933	10,222
April, 1933	9,955
May, 1933	10,004
June, 1933	10,023
July, 1933	9,786
August, 1933	9,809
September, 1933	9,716
October, 1933	9,883
November, 1933	10,003
December, 1933	9,787
January, 1934	10,358
February, 1934	11,074
March, 1934	11,013
April, 1934	10,993
May, 1934	10,869
June, 1934	10,638
July, 1934	10,701
August, 1934	10,620
September, 1934	10,309
October, 1934	10,524
November, 1934	10,634
December, 1934	10,378
January, 1935	11,062
February, 1935	11,426
March, 1935	10,731
April, 1935	10,858
May, 1935	10,946
June, 1935	10,802
July, 1935	10,662
August, 1935	10,765
September, 1935	10,738
October, 1935	10,989
November, 1935	11,079
December, 1935	11,324
January, 1936	11,414
February, 1936	11,408
March, 1936	11,463
April, 1936	11,894
May, 1936	11,304
June, 1936	10,545
July, 1936	9,863
August, 1936	10,004
September, 1936	10,137
October, 1936	9,454
November, 1936	10,204
December, 1936	9,687
January, 1937	10,771
February, 1937	10,941
March, 1937	10,990
April, 1937	11,703
May, 1937	11,002
June, 1937	11,403
July, 1937	10,914
August, 1937	10,712
September, 1937	9,805
October, 1937	10,004
November, 1937	11,590
December, 1937	8,903

Receipts from Patients

September, 1932	1,244,635.00
*October, 1932	1,248,504.00
*November, 1932	1,206,405.00
December, 1932	1,258,672.00
January, 1933	1,331,825.00
February, 1933	1,234,741.00
March, 1933	1,271,784.00
April, 1933	1,284,895.00
May, 1933	1,342,120.00
June, 1933	1,333,867.00
July, 1933	1,290,472.00
August, 1933	1,310,558.00
September, 1933	1,283,945.00
October, 1933	1,304,642.00
November, 1933	1,293,923.00
December, 1933	1,268,788.00
January, 1934	1,373,274.00
February, 1934	1,357,394.00
March, 1934	1,479,786.00
April, 1934	1,529,596.00
May, 1934	1,549,902.00
June, 1934	1,543,631.00
July, 1934	1,495,036.00
August, 1934	1,469,074.00
September, 1934	1,412,009.00
October, 1934	1,537,002.00
November, 1934	1,520,135.00
December, 1934	1,446,092.00
January, 1935	1,506,382.00
February, 1935	1,562,412.00
March, 1935	1,563,621.00
April, 1935	1,536,286.00
May, 1935	1,565,526.76
June, 1935	1,528,129.00
July, 1935	1,514,901.00
August, 1935	1,522,877.00
September, 1935	1,516,305.00
October, 1935	1,534,179.00
November, 1935	1,546,341.00
December, 1935	1,552,421.00
January, 1936	1,561,623.00
February, 1936	1,559,611.00
March, 1936	1,612,982.00
April, 1936	1,915,277.00
May, 1936	1,536,408.00
June, 1936	1,657,474.00
July, 1936	1,490,688.00
August, 1936	1,535,688.00
September, 1936	1,457,640.00
October, 1936	1,520,719.21
November, 1936	1,465,067.52
December, 1936	1,272,765.60
January, 1937	1,539,576.00
February, 1937	1,516,917.60
March, 1937	1,672,002.72
April, 1937	1,694,262.24
May, 1937	1,776,046.32
June, 1937	1,646,881.92
July, 1937	1,728,112.32
August, 1937	1,773,724.32
September, 1937	1,496,919.68
October, 1937	1,679,252.40
November, 1937	1,624,680.72
December, 1937	1,491,132.24

Operating Expenditures

*September, 1932	1,508,519.00
*October, 1932	1,515,582.00
*November, 1932	1,488,989.00
December, 1932	1,568,845.00
January, 1933	1,546,747.00
February, 1933	1,490,075.00
March, 1933	1,585,755.00
April, 1933	1,531,870.00
May, 1933	1,536,710.00
June, 1933	1,545,307.00
July, 1933	1,555,554.00
August, 1933	1,555,701.00
September, 1933	1,579,869.00
October, 1933	1,611,151.00
November, 1933	1,620,478.00
December, 1933	1,651,676.00
January, 1934	1,680,330.00
February, 1934	1,648,750.00
March, 1934	1,716,400.00
April, 1934	1,723,237.00
May, 1934	1,763,407.00
June, 1934	1,757,885.00
July, 1934	1,800,817.00
August, 1934	1,782,184.00
September, 1934	1,770,998.00
October, 1934	1,815,650.00
November, 1934	1,830,598.00
December, 1934	1,846,180.00
January, 1935	1,883,938.00
February, 1935	1,888,570.00
March, 1935	1,773,343.00
April, 1935	1,813,947.00
May, 1935	1,826,149.93
June, 1935	1,810,623.00
July, 1935	1,736,856.00
August, 1935	1,795,539.00
September, 1935	1,828,619.00
October, 1935	1,831,115.00
November, 1935	1,849,120.00
December, 1935	1,897,615.00
January, 1936	1,934,852.00
February, 1936	1,929,623.00
March, 1936	1,954,182.00
April, 1936	1,897,523.00
May, 1936	1,871,964.00
June, 1936	1,921,027.68
July, 1936	1,689,696.00
August, 1936	1,847,736.00
September, 1936	1,896,120.00
October, 1936	1,918,931.76
November, 1936	1,817,101.44
December, 1936	1,568,264.40
January, 1937	1,864,748.16
February, 1937	1,890,667.44
March, 1937	1,969,652.16
April, 1937	2,180,839.60
May, 1937	1,988,845.92
June, 1937	1,990,221.12
July, 1937	1,933,971.84
August, 1937	2,066,890.32
September, 1937	2,058,107.72
October, 1937	2,140,030.08
November, 1937	1,958,306.24
December, 1937	1,891,580.40



Average Occupancy on 100 Per Cent Basis

August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.7
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1
*October, 1932	51.6
*November, 1932	52.2
December, 1932	52.6
January, 1933	56.2
February, 1933	57.0
March, 1933	57.2
April, 1933	55.7
May, 1933	56.0
June, 1933	56.1
July, 1933	54.7
August, 1933	54.9
September, 1933	54.4
October, 1933	55.3
November, 1933	56.0
December, 1933	54.7
January, 1934	57.9
February, 1934	62.0
March, 1934	61.6
April, 1934	61.5
May, 1934	60.8
June, 1934	59.5
July, 1934	59.9
August, 1934	59.4
September, 1934	57.7
October, 1934	58.9
November, 1934	59.5
December, 1934	58.1
January, 1935	61.9
February, 1935	63.96
March, 1935	60.07
April, 1935	60.78
May, 1935	61.09
June, 1935	60.02
July, 1935	58.6
August, 1935	59.8
September, 1935	60.1
October, 1935	61.4
November, 1935	62.1
December, 1935	65.8
January, 1936	66.2
February, 1936	66.18
March, 1936	67.6
April, 1936	70.0
May, 1936	69.1
June, 1936	66.3
July, 1936	63.9
August, 1936	65.7
September, 1936	70.0
October, 1936	67.1
November, 1936	72.5
December, 1936	68.8
January, 1937	70.9
February, 1937	73.05
March, 1937	69.98
April, 1937	73.0
May, 1937	72.48
June, 1937	72.35
July, 1937	68.58
August, 1937	68.05
September, 1937	63.25
October, 1937	63.09
November, 1937	69.8
December, 1937	63.0

*One hospital closed during construction program.

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POSITIONS OPEN

ANAESTHETIST: With experience. 200-bed hospital, New England states. Excellent salary to qualified applicant. Interstate Physicians & Hospital Bureau, 332 Bulkley Bldg., Cleveland, Ohio.

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POSITIONS: Practices, locations, all states, for nurses, doctors, dentists — technicians. All kinds institutional employees furnished. Practices, hospitals sold. Estab. 1904. F. B. Kniest, R. P., 1537 S. 29th St., Omaha, Nebraska. tf.

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NAME BARS FOR NURSES. C. B. Dyer, 234 Massachusetts Ave., Indianapolis, Ind.

DIPLOMAS: One or a thousand—write for Circular II. showing forms for nurses and interns.
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Ophthalmia Neonatorum . . .

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5. To prepare the saline solution, use two drams of sodium chloride to one quart of warm water. Test for temperature by pouring over the wrist (it should be about body temperature).
6. Pour the solution into irrigating can.
   Note:—All preparations are made before baby is removed from his bed.
7. Wrap the baby in warm blanket—mummy fashion. Fasten the rubber bib snugly around the neck to prevent the clothing from getting wet.
8. Inspect the eyes to determine which appears to have the least discharge.
9. Place child on side of cleanest eye, head resting on small towel. The face is placed at edge of opening in table.
10. Remove rubber tip from hook with right hand and hold pencilwise between thumb and forefinger. Permit solution to flow until tubing is warm.
11. Moisten a piece of cotton by allowing the warm solution to flow over it, and by using the left hand wipe the eyelids carefully and gently from the inner canthus outward. Discard the cotton ball into paper bag. This removes much of the discharge that has collected on the outside of the lids. Be very careful that the eye is closed as the cotton may injure the cornea if the eye is open.
    Note: Dry cotton is never used on eyes as lint and coarse particles of cotton act as a foreign body and tend to produce further irritation to cornea or cause an excoriation of the lids.
12. Allow the solution to flow over the closed eye to soften any dried exudate which may have formed there. Hold the tip about one-half inch from the inner canthus of the eye and direct the solution toward the side of the nose, allowing it to flow from the inner canthus outward, never permitting the force of the solution to strike the cornea.
13. Open the left eye by pulling the upper lid up with third finger of left hand and lower lid down with third finger of right hand. The lids are easily everted during the acute stage of infection. Pressure is exerted only on the bones of the orbit after the lids have been carefully opened. No pressure is made directly over the eyeball.
14. Irrigate freely, washing away adherent shreds of pus by carefully moving the lids up and down. Inspect the eye carefully after irrigating to be sure that it is clean.
15. Open the right eye by using forefinger of left hand on upper lid and thumb of left hand on lower lid.
16. After each eye is thoroughly irrigated, dry the lids with a piece of cotton dampened and squeezed dry.
17. Wipe face, neck, and hair with dry cotton.
18. See that clothing is dry and return baby to bed.
19. Wash hands thoroughly.
20. Remove contaminated rubber tip and discard into solution of green soap.
21. Wash hands again.
22. Cleanse drain board with whisk broom, using green soap. Scald with hot water and dry if necessary.